No. 23-2103

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

JENNIFER L. BECKETT-LYNN,
Individually, and as Personal Representative
of the Estate of Keith Lynn,
Plaintiff-Appellant

v.

UNITED STATES OF AMERICA,
Defendant-Appellee

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA

JOINT APPENDIX
(CORRECTED)

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APPEAL,CLOSED

U.S. District Court
District of South Carolina (Charleston)
CIVIL DOCKET FOR CASE #: 2:20-cv-04277-JD

Lynn et al v. United States of America
Assigned to: Honorable Joseph Dawson, III
Case in other court: United States Court of Appeals for the Fourth Circ, 23-02103
Cause: 28:2674 Federal Tort Claims Act

Date Filed: 12/09/2020
Date Terminated: 04/04/2023
Jury Demand: None
Nature of Suit: 362 Personal Inj. Med. Malpractice
Jurisdiction: U.S. Government Defendant

Plaintiff

Keith Lynn

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Date Filed	#	Docket Text
12/09/2020	1	COMPLAINT against United States of America (Filing fee $ 402 receipt number 0420-9522354.), filed by Keith Lynn, Jennifer Lynn. Service due by 3/9/2021. (Attachments: # 1 Exhibit Declaration of Allen Jacobs). (vdru,) (Entered: 12/11/2020)
12/09/2020	2	Local Rule 26.01 Answers to Interrogatories by Jennifer Lynn, Keith Lynn.(vdru,) (Entered: 12/11/2020)
12/09/2020	3	Summons Issued as to United States of America (U.S. Attorney for SC District). (vdru,) (Entered: 12/11/2020)
01/12/2021	5	Case Reassigned to Judge Honorable Joseph Dawson, III. Judge Honorable Margaret B Seymour no longer assigned to the case. (glev,) (Entered: 01/12/2021)
02/12/2021	6	ANSWER to 1 Complaint by United States of America.(Berlinsky, Lee) (Main Document 6 replaced on 2/12/2021) (rweb,). Modified on 2/12/2021 to correct case number on document as verified by filing user (rweb,). (Entered: 02/12/2021)
02/12/2021	7	Local Rule 26.01 Answers to Interrogatories by United States of America.(Berlinsky, Lee) (Main Document 7 replaced on 2/12/2021) (rweb,). Modified on 2/12/2021 to correct case number on document as verified by filing user (rweb,). (Entered: 02/12/2021)
03/12/2021	8	**SCHEDULING ORDER Rule 26(f) Conference Deadline 4/2/2021, 26(a) Initial Disclosures due by 4/16/2021, Rule 26 Report due by 4/16/2021, Motions to Amend Pleadings due by 5/7/2021, Plaintiffs ID of Expert Witness due by 6/7/2021, Defendants ID of Expert Witnesses Due by 7/7/2021, Records Custodian Affidavit due by 7/7/2021, Discovery due by 9/7/2021, Motions due by 10/7/2021, Jury Selection Deadline 1/5/2022, Mediation Due by 9/7/2021, Signed by Honorable Joseph Dawson, III on 3/12/21. (rweb,)** (Entered: 03/12/2021)
03/12/2021	9	**MEDIATION ORDER Mediation Due by 9/7/2021, Signed by Honorable Joseph Dawson, III on 3/12/21. (rweb,)** (Entered: 03/12/2021)
03/15/2021	10	NOTICE of Request for Protection from Court Appearance by Lee Ellis Berlinsky for April 5, 2021 - April 8, 2021 (Berlinsky, Lee) (Entered: 03/15/2021)
03/15/2021	11	NOTICE of Request for Protection from Court Appearance by Lee Ellis Berlinsky for August 3, 2021 - August 6, 2021 (Berlinsky, Lee) (Entered: 03/15/2021)
03/15/2021	12	NOTICE of Request for Protection from Court Appearance by Lee Ellis Berlinsky for August 9, 2021 - August 11, 2021 (Berlinsky, Lee) (Entered: 03/15/2021)
03/24/2021	13	Joint Rule 26(f) Report by Jennifer Lynn, Keith Lynn.(Tinkler, William) (Entered: 03/24/2021)
03/29/2021	14	**AMENDED SCHEDULING ORDER. 26(a) Initial Disclosures due by 6/15/2021, Rule 26 Report due by 6/15/2021, Motions to Amend Pleadings due by 7/6/2021, Plaintiffs ID of Expert Witness due by 8/6/2021, Defendants ID of Expert Witnesses Due by 9/6/2021, Records Custodian Affidavit due by 9/6/2021, Discovery due by 11/8/2021, Motions due by 12/6/2021, Jury Selection Deadline 2/7/2022, Mediation Due by 11/8/2021, Signed by Honorable Joseph Dawson, III on 3/29/21. (rweb,)** (Entered: 03/29/2021)
05/28/2021	15	NOTICE of Request for Protection from Court Appearance by Lee Ellis Berlinsky for July 12 - July 16, 2021 (Berlinsky, Lee) (Entered: 05/28/2021)
06/15/2021	16	Local Rule 26.03 Answers to Interrogatories by United States of America.(Berlinsky, Lee) (Entered: 06/15/2021)
06/15/2021	17	Local Rule 26.03 Answers to Interrogatories by Jennifer Lynn, Keith Lynn.(Tinkler, Paul) (Entered: 06/15/2021)

08/06/2021	18	PLAINTIFF'S ID OF EXPERT WITNESSES by Jennifer Lynn, Keith Lynn.(Tinkler, Paul) (Entered: 08/06/2021)
09/07/2021	19	DEFENDANT'S ID OF EXPERT WITNESSES by United States of America.(Berlinsky, Lee) (Main Document 19 replaced on 9/8/2021) (rweb,). Modified on 9/8/2021 to correct case number on document as verified by filing user (rweb,). (Entered: 09/07/2021)
11/10/2021	20	Joint MOTION to Amend/Correct *the Scheduling Order* by Jennifer Lynn, Keith Lynn. Response to Motion due by 11/29/2021. Add an additional 3 days only if served by mail or otherwise allowed under Fed. R. Civ. P. 6 or Fed. R. Crim. P. 45. Proposed order is being emailed to chambers with copy to opposing counsel.(Tinkler, William) (Entered: 11/10/2021)
11/16/2021	22	**TEXT ORDER granting 20 Motion to Amend/Correct. Signed by Honorable Joseph Dawson, III on 11/16/21. (rweb,)** (Entered: 11/16/2021)
11/16/2021	23	**SECOND AMENDED SCHEDULING ORDER; Plaintiffs ID of Expert Witness due by 12/31/2021, Defendants ID of Expert Witnesses Due by 1/31/2022, Records Custodian Affidavit due by 1/31/2022, Discovery due by 3/31/2022, Motion in Limine due by 5/1/2022, Motions due by 5/1/2022, Jury Selection Deadline 6/1/2022, Mediation Due by 4/15/2022. Signed by Honorable Joseph Dawson, III on 11/16/21. (rweb,)** (Entered: 11/16/2021)
11/19/2021	24	NOTICE of Request for Protection from Court Appearance by Lee Ellis Berlinsky for November 22-24, 2021 (Berlinsky, Lee) (Entered: 11/19/2021)
12/15/2021	25	NOTICE of Request for Protection from Court Appearance by Lee Ellis Berlinsky for December 20-23, 2021 and December 27-30, 2021 (Berlinsky, Lee) (Entered: 12/15/2021)
01/03/2022	26	PLAINTIFF'S ID OF EXPERT WITNESSES by Jennifer Lynn, Keith Lynn.(Tinkler, William) (Entered: 01/03/2022)
03/24/2022	27	Joint MOTION to Amend/Correct *Scheduling Order* by Jennifer Lynn, Keith Lynn. Response to Motion due by 4/7/2022. Add an additional 3 days only if served by mail or otherwise allowed under Fed. R. Civ. P. 6 or Fed. R. Crim. P. 45. Proposed order is being emailed to chambers with copy to opposing counsel.(Tinkler, William) (Entered: 03/24/2022)
03/31/2022	29	**TEXT ORDER granting 27 Joint Motion to Amend Scheduling Order. Signed by Honorable Joseph Dawson, III on 3/31/22.(rweb,)** (Entered: 03/31/2022)
03/31/2022	30	**THIRD AMENDED SCHEDULING ORDER; Discovery due by 3/31/2022, Motion in Limine due by 5/1/2022, Motions due by 5/1/2022, Bench Trial Deadline 6/1/2022, Mediation Due by 4/22/2022. All other dates set out. Signed by Honorable Joseph Dawson, III on 3/31/22. (rweb,)** (Entered: 03/31/2022)
05/02/2022	32	Consent MOTION Status Conference Hearing To Be Set By The Court by United States of America. Response to Motion due by 5/16/2022. Add an additional 3 days only if served by mail or otherwise allowed under Fed. R. Civ. P. 6 or Fed. R. Crim. P. 45. No proposed order.(Berlinsky, Lee) (Entered: 05/02/2022)
05/02/2022	33	RULE 26(a)(3)PRETRIAL DISCLOSURES by United States of America. Objections to PreTrial Disclosures due by 5/16/2022.(Berlinsky, Lee) (Entered: 05/02/2022)
05/02/2022	34	MOTION in Limine by United States of America. Response to Motion due by 5/16/2022. Add an additional 3 days only if served by mail or otherwise allowed under Fed. R. Civ. P. 6 or Fed. R. Crim. P. 45. No proposed order. (Berlinsky, Lee) (Entered: 05/02/2022)
05/10/2022	36	NOTICE of Request for Protection from Court Appearance by Lee Ellis Berlinsky for July 5-11, 2022; July 15, 2022 and August 8-9, 2022 (Berlinsky, Lee) (Entered: 05/10/2022)
05/10/2022	37	NOTICE of Hearing: Telephone Conference set for 5/12/2022 01:00 PM before Honorable Joseph Dawson III. The parties have circulated conference line information. (rweb,) (Entered: 05/10/2022)
05/12/2022	38	**MINUTE ENTRY: The Court held a telephonic status conference pursuant to 37 NOTICE of Hearing: Telephone Conference set for 5/12/2022. The parties discussed scheduling and are directed to confirm their availability by May 19, 2022, for a bench trial as discussed during the status conference. In consideration of the foregoing, 32 Joint Motion for a Status Conference Hearing is denied as it is moot. Proceedings held before Honorable Joseph Dawson, III: finding as moot 32 Motion ; Telephone Conference held on 5/12/2022. (rweb,)** (Entered: 05/12/2022)
05/16/2022	39	RESPONSE in Opposition re 34 MOTION in Limine Response filed by Jennifer Lynn, Keith Lynn.Reply to Response to Motion due by 5/23/2022 Add an additional 3 days only if served by mail or otherwise allowed under Fed. R. Civ. P. 6. (Attachments: # 1 Ex. A - SF-95s, # 2 Ex. - B - Jacobs Dep.)(Tinkler, William) (Entered: 05/16/2022)
06/03/2022	42	NOTICE of Hearing: Bench Trial set for 8/15/2022 09:30 AM in Charleston Courtroom #1, J. Waties Waring Judicial Center, 83 Meeting St, Charleston before Honorable Joseph Dawson III. Bench Trial set for 8/16/2022 09:30 AM in Charleston Courtroom #1, J. Waties Waring Judicial Center, 83 Meeting St, Charleston before Honorable Joseph Dawson III. Bench Trial set for 8/17/2022 09:30 AM in Charleston Courtroom #1, J. Waties Waring Judicial Center, 83 Meeting St, Charleston before Honorable Joseph Dawson III. Bench Trial set for 8/18/2022 09:30 AM in Charleston Courtroom #1, J. Waties Waring Judicial Center, 83 Meeting St, Charleston before Honorable Joseph

		Dawson III. Bench Trial set for 8/19/2022 09:30 AM in Charleston Courtroom #1, J. Waties Waring Judicial Center, 83 Meeting St, Charleston before Honorable Joseph Dawson III. (rweb,) (Entered: 06/03/2022)
06/30/2022	43	Consent MOTION to Continue *the Trial Set For August 15, 2022,* by United States of America. Response to Motion due by 7/14/2022. Add an additional 3 days only if served by mail or otherwise allowed under Fed. R. Civ. P. 6 or Fed. R. Crim. P. 45. No proposed order.(Berlinsky, Lee) (Entered: 06/30/2022)
07/07/2022	45	**TEXT ORDER granting 43 Consent Motion for Continuance of Trial Currently Set for August 15, 2022; the parties are directed to meet and confer regarding their dates of availability through the end of this year for a rescheduled trial. The parties are directed to provide this information to dawson_ecf@scd.uscourts.gov within 10 days of this order. Signed by Honorable Joseph Dawson, III on 7/7/22.(rweb,)** (Entered: 07/07/2022)
07/07/2022	46	NOTICE of Cancellation of Hearing: 8/15/22 at 9:30 (rweb,) (Entered: 07/07/2022)
07/25/2022	48	NOTICE of Hearing: Bench Trial set for 11/14/2022 09:30 - 11/18/2022 AM in Charleston Courtroom #2, J. Waties Waring Judicial Center, 83 Meeting St, Charleston before Honorable Joseph Dawson III. (Entered: 07/25/2022)
08/15/2022	50	**ORDER: Defendant's Motion In Limine (DE 34) is denied as provided herein. Signed by the Honorable Joseph Dawson, III on 8/15/2022. (lgib,)** (Entered: 08/15/2022)
10/04/2022	51	NOTICE of Appearance by Martin L Holmes on behalf of United States of America (Holmes, Martin) (Entered: 10/04/2022)
10/14/2022	52	RULE 26(a)(3)PRETRIAL DISCLOSURES by Jennifer Lynn, Keith Lynn. Objections to PreTrial Disclosures due by 10/28/2022.(Tinkler, William) (Entered: 10/14/2022)
10/18/2022	53	Joint MOTION Status Conference re 48 Notice of Hearing by United States of America. Response to Motion due by 11/1/2022. Add an additional 3 days only if served by mail or otherwise allowed under Fed. R. Civ. P. 6 or Fed. R. Crim. P. 45. No proposed order.(Berlinsky, Lee) (Entered: 10/18/2022)
11/11/2022	54	Emergency MOTION to Continue *Trial* by Jennifer Lynn, Keith Lynn. Response to Motion due by 11/28/2022. Add an additional 3 days only if served by mail or otherwise allowed under Fed. R. Civ. P. 6 or Fed. R. Crim. P. 45. No proposed order.(Tinkler, William) (Entered: 11/11/2022)
11/14/2022	55	**ORDER GRANTING CONTINUANCE. Signed by the Honorable Joseph Dawson, III on 11/14/2022. (lgib,)** (Entered: 11/14/2022)
11/15/2022	56	NOTICE of Request for Protection from Court Appearance by Lee Ellis Berlinsky for November 21-23, 2022; November 25, 2022; and December 19-23, 2022 (Berlinsky, Lee) (Entered: 11/15/2022)
11/18/2022	57	STATUS REPORT by Jennifer Lynn, Keith Lynn. (Tinkler, William) (Entered: 11/18/2022)
11/23/2022	58	MOTION for Summary Judgment by United States of America. Response to Motion due by 12/7/2022. Add an additional 3 days only if served by mail or otherwise allowed under Fed. R. Civ. P. 6 or Fed. R. Crim. P. 45. (Attachments: # 1 Exhibit A, Deposition of Dr. Jacobs, # 2 Exhibit B, Deposition of Thomas Brothers, # 3 Exhibit C, Declaration of John Womack, # 4 Exhibit D, Declaration of Mark Jackson, # 5 Exhibit E, Declaration of Jan Fritz)No proposed order.(Holmes, Martin) (Entered: 11/23/2022)
11/23/2022	59	REPLY by Jennifer Lynn, Keith Lynn to 55 Order on Motion to Continue . (Attachments: # 1 Jacobs Declaration) (Tinkler, William) (Entered: 11/23/2022)
12/01/2022	62	RESPONSE in Support re 58 MOTION for Summary Judgment. Response filed by United States of America (Berlinsky, Lee). Modified on 12/2/2022 to correct event type. (prou,) (Entered: 12/02/2022)
12/01/2022	63	REPLY to Response to Motion re 58 MOTION for Summary Judgment Response filed by Jennifer Lynn, Keith Lynn. (Attachments: # 1 Ex. A - USA DOCS_1145-46, # 2 Ex. B - USA DOCS_1744-45, # 3 Ex. C - USA DOCS_1756, # 4 Ex. D - USA DOCS_1757) (Tinkler, William). Modified on 12/2/2022 to correct event type(prou,) (Attachment 2 replaced on 12/2/2022) (prou,). Modified on 12/2/2022 to replace Exhibit B per request of filing user (prou,). (Entered: 12/02/2022)
02/10/2023	64	NOTICE of Hearing: Bench Trial set for 5/9/2023 09:30 AM - 5/11/2023 in Charleston Courtroom #2, J. Waties Waring Judicial Center, 83 Meeting St, Charleston before Honorable Joseph Dawson III. (swel,) Modified to correct docket text on 2/10/2023 (cwhi,). (Entered: 02/10/2023)
02/21/2023	65	NOTICE of Request for Protection from Court Appearance by Lee Ellis Berlinsky for March 13-16, 2023; May 12 and May 15, 2023 (Berlinsky, Lee) (Entered: 02/21/2023)
03/16/2023	66	NOTICE of Request for Protection from Court Appearance by Lee Ellis Berlinsky for July 3-7, 2023 and July 28, 2023 (Berlinsky, Lee) (Entered: 03/16/2023)
03/31/2023	67	NOTICE of Request for Protection from Court Appearance by Lee Ellis Berlinsky for April 10-13, 2023 (Berlinsky, Lee) (Entered: 03/31/2023)
04/04/2023	68	**ORDER: The Court grants Defendant summary judgment pursuant to Rule 56(f), Judgment Independent of the Motion, as provided herein; therefore, Plaintiffs' case is dismissed. AND IT IS SO ORDERED. Signed by**

		the Honorable Joseph Dawson, III on 4/4/2023. (lgib,) (Entered: 04/04/2023)
04/04/2023	69	SUMMARY JUDGMENT in favor of United States of America against Keith Lynn and Jennifer Lynn. (lgib,) (Entered: 04/04/2023)
05/02/2023	70	MOTION for Reconsideration re 69 Summary Judgment, 68 Order on Motion for Summary Judgment, by Jennifer Lynn, Keith Lynn. Response to Motion due by 5/16/2023. Add an additional 3 days only if served by mail or otherwise allowed under Fed. R. Civ. P. 6 or Fed. R. Crim. P. 45. No proposed order.(Tinkler, William) (Entered: 05/02/2023)
05/15/2023	71	RESPONSE in Opposition re 70 MOTION for Reconsideration re 69 Summary Judgment, 68 Order on Motion for Summary Judgment, Response filed by United States of America.Reply to Response to Motion due by 5/22/2023 Add an additional 3 days only if served by mail or otherwise allowed under Fed. R. Civ. P. 6. (Attachments: # 1 Exhibit 1: Expert Reports from Defendant (Redacted), # 2 Exhibit 2: November 30, 2021 Email from Berlinsky, # 3 Exhibit 3: November 8, 2022 Email from Tinkler, # 4 Exhibit 4: March 22, 2023 Email from Tinkler, # 5 Exhibit 5: March 24, 2023 Email from Tinkler)(Berlinsky, Lee) (Entered: 05/15/2023)
05/22/2023	72	REPLY to Response to Motion re 70 MOTION for Reconsideration re 69 Summary Judgment, 68 Order on Motion for Summary Judgment, Response filed by Jennifer Lynn, Keith Lynn. (Attachments: # 1 Exhibit A - Email Thread, # 2 Exhibit B - Exhibit List, # 3 Exhibit C - USA N and O)(Tinkler, William) (Entered: 05/22/2023)
07/12/2023	73	**TEXT ORDER: In light of Plaintiffs' 70 Motion for Reconsideration and brief, in which Plaintiffs raised an issue regarding the United States' submission of proposed findings of fact and conclusions of law to the Court ex parte, pursuant to 48 Notice Regarding Bench Trial, the Defendant is directed to provide the proposed findings and conclusions of law to Plaintiffs by July 14, 2023. Thereafter, Plaintiffs are authorized to provide a supplemental memorandum, if any, with respect to any additional or supplemental matters in support of their Motion for Reconsideration by July 28, 2023. Signed by the Honorable Joseph Dawson, III on 7/12/2023. (lgib,)** (Entered: 07/12/2023)
07/28/2023	75	REPLY by Jennifer Lynn, Keith Lynn to 73 Order,, . (Attachments: # 1 Exhibit A - United States' Proposed Order) (Tinkler, William) (Entered: 07/28/2023)
08/04/2023	77	RESPONSE in Opposition re 70 MOTION for Reconsideration re 69 Summary Judgment, 68 Order on Motion for Summary Judgment, Response filed by United States of America.Reply to Response to Motion due by 8/11/2023 Add an additional 3 days only if served by mail or otherwise allowed under Fed. R. Civ. P. 6. (Berlinsky, Lee) (Entered: 08/04/2023)
08/24/2023	78	**ORDER: The Court denies Plaintiffs' motion for reconsideration. IT IS SO ORDERED. Signed by the Honorable Joseph Dawson, III on 8/24/2023. (lgib,)** (Entered: 08/24/2023)
10/19/2023	79	NOTICE OF APPEAL as to 69 Summary Judgment, 68 Order on Motion for Summary Judgment, 78 Order on Motion for Reconsideration by Jennifer Lynn, Keith Lynn. - Filing fee $ 505, receipt number ASCDC-11381613. The Docketing Statement form, Transcript Order form and CJA 24 form may be obtained from the Fourth Circuit website at www.ca4.uscourts.gov (Tinkler, William) (Entered: 10/19/2023)
10/19/2023	80	Transmittal Sheet for Notice of Appeal to USCA re 79 Notice of Appeal, The Clerk's Office hereby certifies the record and the docket sheet available through ECF to be the certified list in lieu of the record and/or the certified copy of the docket entries. (lgib,) (Entered: 10/19/2023)

PACER Service Center

Transaction Receipt

02/05/2024 12:55:16

PACER Login:	JasonLuck	**Client Code:**	
Description:	Docket Report	**Search Criteria:**	2:20-cv-04277-JD
Billable Pages:	6	**Cost:**	0.60
Exempt flag:	Not Exempt	**Exempt reason:**	Not Exempt

UNITED STATES DISTRICT COURT
DISTRICT OF SOUTH CAROLINA
CHARLESTON DIVISION

Keith Lynn and Jennifer Lynn, Plaintiffs, vs. United States of America, Defendant.	Case No. **2:20-cv-4277-MBS** **COMPLAINT** **(28 U.S.C. § 2674)**

Plaintiffs Keith Lynn and Jennifer Lynn, complaining of Defendant United States of America, hereby allege as follows:

Parties, Jurisdiction, and Venue

1. Plaintiff Keith Lynn ("Keith") resides in the State of South Carolina and has been a patient at the U.S. Department of Veterans Affairs ("VA") facility in Charleston, South Carolina.

2. Plaintiff Jennifer Lynn ("Jennifer") resides in the State of South Carolina. She is married to Keith and resides with him.

3. Defendant United States of America is a body politic that operates through its executive branch an agency of government known as the VA, which, among other services, provides health care services to veterans of the U.S. military branches. At all times material to this action, Defendant, through the VA, was responsible for the correct response to Keith's health care needs.

4. Plaintiffs, pursuant to the Federal Tort Claims Act, 28 U.S.C. § 2671, *et seq*. (hereinafter "FTCA"), seek compensatory damages arising from Defendant's negligence in failing to adhere to the prevailing professional standard of care that is generally recognized as acceptable and appropriate by reasonably prudent similar health care providers.

5. Jurisdiction is proper in that this action is premised upon federal causes of action under the FTCA. Specifically, the Court has jurisdiction of the instant action pursuant to 28 U.S.C. § 1331, in that this case arises under the FTCA, and pursuant to 28 U.S.C. § 1346, in that this Court has original jurisdiction over all claims against the United States of America and the various agencies thereof, including the VA.

6. Pursuant to the FTCA, Plaintiffs, on or about October 4, 2019, presented their claims to the appropriate federal agency for administrative settlement. As of the date of this filing, Plaintiffs have received neither a denial nor an acceptance of their claims.

7. Venue is proper in this district pursuant to 28 U.S.C. § 1402(b), as Plaintiffs reside this judicial district and the events or omissions giving rise to the claims occurred in this judicial district.

Cause of Action for Medical Negligence (Keith Lynn)

8. On or about January 15, 2019, Keith presented at the VA's Charleston facility with pain and swelling of his right leg. At that time, Keith had a history of pain and swelling of his leg and was being followed by podiatrists at the VA for a diagnosis of Charcot's joint disease.

9. After presentation on January 15, 2019, the non-podiatry staff at the VA diagnosed osteomyelitis and performed a below the knee amputation of Keith's right leg.

10. That there was insufficient evidence to support a diagnosis of osteomyelitis and the amputation performed on January 17, 2019, was unnecessary.

11. That, subsequent to the amputation in January 2019, complications developed, requiring amputation of the leg above the knee.

12. That Defendant failed to adhere to the applicable standards of care, such that Defendant's failures deviated from the applicable standard of care imposed upon the doctors.

13. That, as a direct and proximate result of Defendant's negligence, Keith has suffered damage in that his right leg has been amputated above the knee. This has resulted in pain and suffering, disability, disfigurement, loss of enjoyment of life, and other actual damages.

Cause of Action for Loss of Consortium (Jennifer Lynn)

14. Jennifer incorporates and re-alleges the allegations of Paragraphs 1 through 13 as if they were set forth herein verbatim.

15. As a direct and proximate result of Keith's disability caused by Defendant's negligence, Jennifer has suffered a loss of consortium. In particular, Keith's amputation and confinement to a wheelchair necessitated Jennifer to provide continuous care for him, and she has therefore experienced a loss of Keith's companionship, aid, society, and services that she enjoyed before Defendant's negligent acts.

Wherefore, Plaintiffs Keith Lynn and Jennifer Lynn pray for a judgment against Defendant United States of America for their actual damages as may be determined by this Court in a sum that is fair and just and consistent with Plaintiffs' submitted claims.

Respectfully submitted,

TINKLER LAW FIRM LLC

/s/ Paul E. Tinkler

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Counsel for Plaintiffs

December 9, 2020

DECLARATION OF ALLEN MARK JACOBS DPM, FACFAS, FAPWH

1. I have reviewed in detail the medical records forwarded to me by Keith Lynn's counsel. The majority of the records reviewed were from the Charleston South Carolina Veterans Administration Medical Center.

2. Based upon my review of these medical records, it appears that Mr. Lynn underwent an unnecessary below the knee amputation of his right leg. The medical records appear to indicate that Mr. Lynn was being followed by the podiatry service at the South Carolina Veterans Administration Medical Center for a diagnosis of Charcot's joint disease.

3. The medical records indicate that Mr. Lynn presented with signs and symptoms consistent with Charcot's joint disease. On admission to the hospital following examination in the emergency department, and was found to be afebrile, with no laboratory studies which supported the diagnosis of acute infection or osteomyelitis. Mr. Lynn presented with radiographic changes consistent with Charcot's joint disease, possibly with an associated soft tissue infection and abscess of undetermined etiology.

4. Specifically, on January 15, 2019, Mr. Lynn presented to the emergency department of the Charleston South Carolina Veterans Administration Hospital. His records indicate that he has multiple history of Charcot's joint disease. The records indicate that he was afebrile, and demonstrated no signs or symptoms suggestive of acute infection or sepsis. The records indicate no elevation in his white blood cell count/leukocytosis. The records indicate the presence of no open wound or ulceration.

5. A CT scan was performed which was interpreted as demonstrating evidence of advanced chronic osteomyelitis, and the presence of an abscess. In actuality the CT scan changes demonstrated findings consistent with Charcot joint disease and not advanced

osteomyelitis. If, in fact, an abscess had been present, this could have been properly treated by incision and drainage and not urgent amputation of the right leg. It appears the decision to perform an amputation was based upon the possible existence of an abscess in the soft tissues, as well as the misinterpretation of the x-ray changes as osteomyelitis, rather than Charcot joint disease. Furthermore, although less likely, Mr. Lynn suffered from gouty arthritis, which may have been a contributing factor to his swelling, redness, pain, and radiographic/CT changes.

6. Mr. Lynn presented repeatedly for evaluation at the Charleston South Carolina Veterans Administration Hospital for the evaluation of edema in both the left and right lower extremity. The podiatry attending staff made a diagnosis of Charcot's joint disease and were actively treating Mr. Lynn for this problem up to 48 hours prior to his admission to the Charleston South Carolina Veterans Administration Hospital and eventual amputation of his right leg. Mr. Lynn underwent multiple venous Doppler studies for his edema. Edema represents the first clinical stage of Charcot's joint disease. His venous Doppler studies were negative. Mr. Lynn underwent multiple radiographic imaging studies of his left and right foot and ankle and leg, including CT scan and MRI study. Again, the MRI studies demonstrated bone marrow edema typical of Charcot's joint disease. Imaging studies of Mr. Lynn's right lower extremity demonstrated multiple bones and joints affected, more typical of Charcot's joint disease and not osteomyelitis.

7. It appears that the non-podiatric medical staff of the Charleston South Carolina Veterans Administration Hospital was unfamiliar with Charcot's joint disease, which occurs with frequency in a patient with diabetes, neuropathy, and concurrent pathology such as obesity.

8. If in fact Mr. Lynn suffered from an abscess, this could have been treated by incision and drainage. Instead, the imaging studies which demonstrated changes consistent with

Charcot joint disease were misinterpreted as being that of osteomyelitis, and his right leg sacrificed as a result of this misinterpretation.

9. The medical records of Mr. Lynn indicate the presence of no open wound or ulceration or other potential etiology to account for the presence of an abscess in the right leg.

10. Following amputation of his right leg, the pathology report documented no evidence of ulceration, or infection to support the need for urgent amputation of the right leg.

11. My opinions in this matter are expressed with a reasonable degree of medical certainty. My opinions are based upon my review of the medical records provided to me, as well as my experience greater than 40 years treating patients such as Mr. Lynn who suffer from diabetes, neuropathy and Charcot joint disease. A copy of my curriculum vitae is attached hereto.

Review of Medical Records

12. Mr. Lynn had a long history of receiving medical care for a variety of complaints and concerns from the Charleston South Carolina Veterans Administration Hospital. He suffered from multiple pathologic issues including diabetes, morbid obesity, diabetic neuropathy, hypertension, and anxiety/depression, factor V laden mutation, gout, sleep apnea, cardiopulmonary disease, history of prior DVT.

13. On May 18, 2018, Mr. Lynn presented with bilateral edema of the lower extremities. No open wound or ulceration was described. Venous Dopplers were performed which were negative for DVT.

14. It should be noted that swelling (edema) is the first clinical manifestation of Charcot's joint disease.

15. Mr. Lynn presented initially with right foot and leg swelling on June 21, 2018.

He was evaluated in emergency department of the South Carolina Veterans Administration Hospital. He was not diagnosed with any open wound, ulceration or sepsis.

16. Radiographs were obtained of the right ankle on this date. Soft tissue swelling was present. There was no evidence of fracture, dislocation, or infection including osteomyelitis.

17. Edema is typically the initial clinical presentation for Charcot's joint disease.

18. The venous Doppler were performed given a suspected thrombosis was also obtained given the extent of swelling present. There was no evidence on Doppler examination of any DVT.

19. Mr. Lynn was again evaluated in the emergency department July 9, 2018 for right ankle and foot pain and swelling. He was diagnosed with gouty arthritis. There was no indication of any ulceration, soft tissue infection, or osteomyelitis. He was prescribed colchicine or standard treatment of gouty arthritis.

20. The extent of the swelling and pain in the right lower extremity was significant, prompting a venous Doppler study to rule out DVT. This study was negative for evidence of venous thrombosis.

21. On July 20, Mr. Lynn was again evaluated with swelling and pain in the right ankle joint. He was evaluated in the emergency department of the Charleston South Carolina Veterans Administration Hospital. He was not diagnosed with any sections process.

22. An MRI of the right foot was performed on July 28, 2018. The testing was ordered by Dr. Stephen O'Connor with "a concern for osteomyelitis?". The MRI demonstrated edema of the soft tissues with bone marrow edema in the distal tibia, talus, calcaneus, navicular, cuboid, and cuneiform bones. The interpretation was that of soft tissue swelling and "neuropathic joint is favored over osteomyelitis".

23. The MRI on this date was consistent with Charcot's joint disease which begins with bone marrow edema. Given the absence of any open wound or ulceration, the afebrile state of Mr. Lynn with no signs or symptoms of systemic infection (no fever, malaise, fatigue, tachycardia, tachypnea, leukocytosis) the MRI findings are absolutely consistent with Charcot's joint disease.

24. Radiographs were obtained of the right foot and ankle on July 28, 2018. These radiographs demonstrated changes consistent with Charcot joint disease.

25. On August 13, 2018 he was evaluated by a podiatrist, Dr. Byron, for his right foot and ankle concerns. Mr. Lynn was diagnosed with Charcot joint disease. He was treated in standard matter of Charcot's joint disease with compression, the use of a CROW walker, and a bone stimulator was prescribed. Non-weightbearing with a wheelchair was recommended. He was also prescribed a knee walker in order to decrease weightbearing to his right lower extremity. Radiographic evaluation of the right and left foot on this date demonstrated changes consistent with Charcot joint disease. There was no evidence of osteomyelitis.

26. Radiographs on August 13, 2018 were ordered by Dr. Debbie Byron of the podiatry department. Under reason for study was "concern for Charcot foot/ankle changes". The x-rays demonstrated soft tissue swelling of the right foot. Arthritic changes were noted within the right foot X-rays of the left foot demonstrated mild arthritic changes. The interpretation with reference to the right foot was significant "fairly widespread" soft tissue swelling. No significant morbidities were felt to be present in the left foot.

27. X-rays of the right foot were ordered by Dr. Debbie Byron on October 12, 2018. Under reason for study was "Charcot joint management". The request indicates that there was a history of gouty arthritis. The x-rays demonstrated early irregularity of the mid foot at the

calcaneal cuboid and cuboid cuneiform joints consistent with Charcot's joint disease. The radiographs were interpreted by Dr. Dmitry Havaizhew M.D.

28. On November 19, 2018 he was again followed up by the podiatry service by Dr. Ravenell. Once again, a diagnosis of Charcot's joint disease was made. Swelling and redness and pain were noted with a collapse of the foot consistent with Charcot joint disease. Radiographs were obtained which again demonstrated signs of Charcot's joint disease.

29. One January 15, 2019, 2 days before his amputation, Mr. Lynn was again evaluated by Dr. Ravenell. The medical records indicate that Mr. Lynn was again diagnosed with Charcot's joint disease. At the time of this examination Mr. Lynn demonstrated increased swelling and pain and difficulty wearing his CROW walker boot. The records indicate no suggestion of any infectious disease. The records indicate no open wound or ulceration. Radiographs were obtained on this date of the right leg and foot as well as the right knee. These x-rays demonstrated changes consistent with Charcot joint disease. There was no evidence of abscess, no evidence of osteomyelitis.

30. The x-ray report of this date indicates that radiographs were obtained of the **left foot**. The records indicate that there was some confusion by the radiology department as to whether the x- rays were representative of the left or the right foot. It appears a conclusion was drawn that these x-rays were of the left foot. Soft tissue swelling was noted to be present and periosteal reaction of the distal fibula was noted to be present. Deformity of the foot consistent with Charcot's joint disease was also noted to be present. The radiographs were interpreted as "probably consistent with the history of a Charcot joint". Advancing destructive changes of multiple bones were noted again, consistent with Charcot joint disease. X-rays of the distal leg were also obtained which again demonstrated changes consistent with Charcot's joint disease.

31. Given the **bilateral swelling present in the legs of Mr. Lynn, a venous Doppler was performed**. The Doppler studies demonstrated no evidence of venous thrombosis. However, the degree of edema was sufficient in both lower chest remedies to warrant the performance of a venous Doppler study to rule out blood clot.

32. A CT scan of **the left** calf, ankle and foot was obtained on January 13, 2019. Periosteal changes were noted along the distal fibula which could be seen in Charcot's joint disease. Periosteal change was also noted on the distal tibia again, consistent with Charcot joint disease. A large gas containing fluid collection was noted along the anterior and lateral aspect of the distal leg. The radiographic interpretation was that it was "compatible" with an abscess. Air bubbles and an additional area of fluid collection surrounding the ankle and hindfoot were also noted to be present. Destruction and fragmentation of the calcaneus "compatible" with osteomyelitis was also noted. However, these changes are also consistent with Charcot's joint disease. The radiologist notes that "some component of neuropathic arthropathy could be present as well". It was felt that the changes were less likely associated with Charcot's joint disease. Areas of tendinitis were also noted area periosteal reaction was also noted in multiple bones of the foot including the cuboid, lateral cuneiform, middle cuneiform and talus. The interpretation was that the changes were "consistent" with osteomyelitis. An abscess was also noted.

33. The changes present on the CT scan were consistent with Charcot joint disease and possibly an abscess although, given the absence of any ulceration or entry for bacteria it is difficult to understand how an abscess would have occurred in the leg of Mr. Lynn. He would be somewhat if not extremely unusual to have osteomyelitis of 6 bones in the leg and foot, however, multiple bone involvement is typical for Charcot's joint disease.

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Date of Birth:		[redacted] Philadelphia, Pennsylvania
Education:	1973	Pennsylvania College of Podiatric Medicine
	1969	Temple University, Grd. College - Liberal Arts
	1965	Central High School Philadelphia, Pennsylvania
Surgical Residency Training:	1973-74	Monsignor Clement Kern Hospital For Special Surgery Warren, Michigan
Current Podiatry Licensure:		Missouri: 000436
Certification:	1973	Diplomat, National Board of Podiatric Examiners
	1981	Diplomat, American Board of Podiatric Surgery
	1982	Fellow, American College of Foot and Ankle Surgeons
	2006	Fellow, American Professional Wound Care Association
Recertification:	2000, 2010	American Board of Podiatric Surgery

Society Memberships:

- American Board of Podiatric Surgery
- American College of Foot and Ankle Surgeons
- Missouri State Podiatric Medical Society
- American Podiatric Medical Association
- St. Louis Podiatry Society
- American Diabetes Association
- American Professional Wound Care Association

Current Activities

- Private Practice, St. Louis, MO
- Chairperson, Journal Management Counsel: American College of Foot and Ankle Surgeons
- Editorial Advisory Board: Podiatry Today
- Editorial Advisory Board: Foot and Ankle Quarterly
- Editorial Advisory Board: Clinics in Podiatric Medicine and Surgery
- Adjunct Clinical Professor: St. Louis University School of Medicine

Hospital Affiliations

- St. Louis University Hospital
- Des Peres Hospital
- Christian Hospital Northeast
- St. Anthony's Hospital
- St. Mary's Hospital

Surgery Center Affiliation

- Manchester Surgery Center

Honors and Awards:

1. Pennsylvania College of Podiatric Medicine Alumni Award, 1973. Presented annually to the graduating student maintaining the highest scholastic average over the prior four years.
2. Professor M.H. Samitz Award, 1973. Presented annually to the graduating student maintaining the highest grade point average in dermatology.
3. Professor Louis M. Newman Award, 1973. Presented annually the graduating student demonstrating the greatest proficiency in foot surgery.
4. Clinical Sciences Award, 1973. Presented annually to the graduating student maintaining the highest grade point average in clinical sciences.
5. American College of Foot Roentgenology Award, 1973. Presented for the best thesis in radiology and related sciences for "Radiologic Evaluation of Growth Factors Influencing the Development of Normal Tibial Varum."
6. Professor Vincent A. Jablon Award, 1973. Presented annually to the graduating student maintaining the highest grade point average in diagnostic radiology.
7. Gordon Pharmacology Award, 1973. Presented annually to the graduating student maintaining the highest grade point average in pharmacology.
8. Philadelphia County Podiatric Society Orthopedics Award, 1973. Presented annually to the graduating student maintaining the highest grade point average and demonstrating the greatest proficiency in orthopedics and in biomechanics.

9. Sterling-Hartford Honorary Anatomical Society, 1973. Membership conferred upon the graduating student demonstrating the greatest proficiency in anatomy, histology and embryology.

10. Pi Delta National Podiatric Honor Society, 1973. Membership conferred upon students maintaining a cumulative average over 90% or better in all course work in podiatry college.

11. Who's Who in American Universities and Colleges, 1973.

12. First Place Award, American Podiatric Medical Association Hall of Science, 1980. Given at the American Podiatric Medical Association National Scientific Meeting, Detroit, Michigan, for "Radionuclide Bone Imaging of the Foot and Ankle."

13. First Place Award, American Podiatric Medical Association Hall of Science, 1981. Given at the American Podiatric Medical Association National Scientific Meeting, Fort Lauderdale, Florida, for "Advances in the Management of the Diabetic Foot."

14. Second Place Award for Excellence in Medical Writing, American College of Foot Surgeons, 1981.

15. Second Place Award for Excellence in Medical Writing, American College for Foot Surgeons, 1982.

16. Second Place Award for Excellence in Medical Writing, American College for Foot Surgeons, 1983.

17. Second Place Award for Excellence in Medical Writing, American College for Foot Surgeons, 1984. Presented at ACFS Annual Meeting, Las Vegan, Nevada, for "Tarsal Tunnel Syndrome: A Manifestation of Systemic Disease."

18. Dedication to Podiatry Award, 1984. Texas Podiatric Medical Association.

19. Award of Appreciation for Dedication to the Advancement of Podiatric Medical Education, 1984. Podiatry Society of Virginia.

20. Certificate of Appreciation for the Advancement of Podiatric Education, 1984. Memphis (Tennessee) Podiatry Hospital Association.

21. Award for Dedication of the Advancement of Podiatric Education, 1984. Student National Podiatry Association, Cleveland (Ohio) college of Podiatric Medicine.

22. Third Place Award for Excellence in Medical Writing, American College for Foot Surgeons, 1985.

23. Award for Appreciation for Dedication to Podiatric Education and the Advancement of the Podiatric Profession, 1985. Pittsburgh (Pennsylvania) Podiatry Hospital.

24. Third Place Award for Excellence in Medical Writing, American College for Foot Surgeons, 1986.

25. Third Place Award for Excellence in Medical Writing, American College for Foot Surgeons, 1987.

26. William K. Stickel Award for Medical Writing and Research, American Podiatric Medical Association, 1987.

27. Presidents Lecture, Midwest Conference, 1991.

Academic and Professional Appointments:

1. Director, Podiatry Service, Deaconess Hospital, St. Louis, Missouri, 1988 to 2004.

2. Director, Podiatric Surgical Residency Training, Deaconess Hospital, St. Louis, Missouri, 1987 to 2004.

3. Director, Podiatric Surgical Residency Training, Central Medical Center, St. Louis, Missouri, 1987 to 1992.

4. Contributing Editor, Journal fo Foot Surgery, American College of Foot Surgeons, 1980 to 1990.

5. Special Features Editor, Podiatry Tracts. Williams and Wilkins, Publishers. 1989 to 1992.

6. Review Editor, Journal of Foot Surgery. Williams and Wilkins, Publishers. 1982 to 1988.

7. Contributing Editor, Podiatry Tracts. Williams and Wilkins, Publishers. 1987 to 1992.

8. Scientific Chairman, American Podiatric Medical Association, National Scientific Sessions: 1987, 1988, 1989, 1991.

9. Scientific Chairman, Missouri Podiatric Medical Association, State Meetings: 1982, 1983, 1984, 1985, 1986, 1987, 1988, 1989, 1990, 1991, 1992, 1993, 1994, 1995.

10. Adjunct Clinical Professor, Des Moines (Iowa) College of Osteopathy and Podiatric Medicine, 1986 to 2004.

11. Adjunct Clinical Professor, William Scholl College of Podiatric Medicine, 1998 to 2004.

12. Missouri State Podiatric Peer Review Committee, 1985 to Present.

13. Dow Corning-Wright Corporation, Implant Advisory Committee Member, 1985 to 1987.

14. Instructor, Department of Radiology, Logan college of Chiropractic Medicine, St. Louis, Missouri. 1979 to 1984.

15. Missouri State Pharmacy Formulary committee Member. Appointed by Governor John Ashcroft, 1987 to 1988.

16. Chairman, Department of Podiatric Medicine and Surgery, Veterans Administration Hospital, Washington, D.C., 1978.

17. Associate Director, Podiatric Medical Services, Veterans Administration Central Office, Washington, D.C., 1978.

18. Chairman, Lindell Hospital Department of Podiatric Medicine and Surgery, St. Louis, Missouri, 1981 to 1987.

19. Director and Chairman, Lindell Hospital Podiatric Surgical Residency Training Program, St. Louis, Missouri, 1980 to 1987.

20. Lindell Hospital Tissue Review Committee Member, St. Louis, Missouri, 1979 to 1986.

21. Lindell Hospital Blood Transfusion Review committee Member, St. Louis, Missouri, 1981 to 1987.

22. Lindell Hospital Antibiotic Utilization Review Committee Member, St. Louis, Missouri, 1981 to 1987.

23. Lindell Hospital Infection Control Committee Member, St. Louis, Missouri, 1980 to 1987.

24. Lindell Hospital Medical Executive Committee Member, St. Louis, Missouri, 1980 to 1987.

25. Missouri Medicaid Physician's Advisory Board Member, 1986 to 1987.

26. Chairman, Pennsylvania College of Podiatric Medicine Surgical Credentials Committee, 1977.

27. Assistant Professor of Surgery, Pennsylvania College of Podiatric Medicine, 1977.

28. Director, Pennsylvania College of Podiatric Medicine Master of Science Post-Doctoral Degree Program, 1977.

29. Director, Postgraduate Course on Advanced Rearfoot Surgery, Pennsylvania College of Podiatric Medicine, 1977.

30. Chairman, Podiatric Medical Education Committee and Director of Podiatric Residency Training, Washington Memorial Hospital, Turnersville, New Jersey, 1977 to 1978.

31. Chairman, Podiatric Residency Training Committee, Broad Street Hospital, Philadelphia, Pennsylvania, 1977.

32. Director, Philadelphia Podiatry Residents' Journal club, Pennsylvania College of Podiatric Medicine, 1977.

33. Pennsylvania College of Podiatric Medicine Admissions Committee Member, 1976 to 1977.

34. Pennsylvania College of Podiatric Medicine Emergency Care Committee Member, 1976 to 1977.

35. Washington Memorial Hospital Podiatry Credentials Committee Member, 1976.

36. Co-Chairman, Pennsylvania College of Podiatric Medicine Seminar on Diagnostic Radiologic Techniques of the Lower Extremity, 1976.

37. Co-Chairman, Pennsylvania College of Podiatric Medicine, Department of Surgery, Pediatric Orthopedics Seminar, 1977.

38. Externship Programs Director, Pennsylvania college of Podiatric Medicine Externships at Washington Memorial Hospital, Turnersville, New Jersey, (Podiatric Medicine, Podiatric Surgery, Internal Medicine, Orthopedics, Pediatrics, Physical Therapy and Urology), 1977.

39. Chairman, Symposium on Cavus Foot Deformity, Department of Medical Education, Washington Memorial Hospital, Turnersville, New Jersey, 1977.

40. Chairman, Seminar on Advances in Physical Therapeutics and in the Management of Foot Pathology, Washington Memorial Hospital, Turnersville, New Jersey, 1977.

41. Scientific Chairman, Veterans Administration Regional Medical Education Center, First National Conference on Podiatric Care of the Aging Veteran Patient, Washington, D.C., 1977.

42. Examiner, American College of Foot Surgeons Fellowship Examination Committee, 1983, 1984, 1985.

43. Scientific Chairman, American College of Foot Surgeons Annual Scientific Meeting, Tampa, Florida, 1985.

44. Chairman, Seminar on Management of Lower Extremity Infectious Disease, Central Medical Center, St. Louis, Missouri, 1987.

45. Chairman, Missouri National Podiatric Surgical Seminar, Sheraton Westport Plaza, St. Louis, Missouri, 1989, 1990.

ORIGINAL PUBLICATIONS - Textbook Chapters:

1. Jacobs, Allen M. and Lawrence Oloff. "Fracture Non-Union." Clinics in Podiatry 2 Chapter (2), Pages 379-406. W.B. Saunders, Philadelphia, PA. April, 1985.

2. Jacobs, Allen M. and Lawrence Oloff. "Podiatric Metallurgy and the Effects of Implant Materials on Living Tissue." Clinics in Podiatry 2 Chapter (1), Pages 121-141. W.B. Saunders, Philadelphia, PA. January, 1985.

3. Jacobs, Allen M. And Lawrence Oloff. "Complications of Implant Arthroplasty." Complications in Foot Surgery: Second Edition. Pages 274-308. Williams and Wilkins, Baltimore, MD. 1984.

4. Jacobs, Allen M. And Lawrence Oloff. "The Diabetic Foot." Complications in Foot Surgery: Second Edition. Pages 309-356. Williams and Wilkins, Baltimore, MD. 1984.

5. Jacobs, Allen M. And Lawrence Oloff. "Management of Osteomyelitis." Comprehensive Textbook of Foot Surgery, Volume Two. Pages 1041-1066. Williams and Wilkins, Baltimore, MD. 1987.

6. Jacobs, Allen M., R.J. O'Leary, W.G. Totty and D.C. Hardy. "Magnetic Resonance Imaging of the Foot Ankle." Clinics in Podiatric Medicine and Surgery 4. Pages

121-141. W.B. Saunders, Philadelphia, PA. October, 1987.

7. Jacobs, Allen M. "The Subluxing Peroneal Tendon: Stabilizing Procedures." Current Therapy in Podiatric Surgery. Pages 93-99. B.C. Decker, 1988.

8. Jacobs, Allen M. "Radiographic Evaluation of the Diabetic Foot." Radiology of the Foot: Second Edition. Williams and Wilkins, Baltimore, MD. 1988.

9. Jacobs, Allen M. "Magnetic Resonance Imaging for Bone and Joint Disorders." Radiology of the Foot: Second Edition. Williams and Wilkins, Baltimore, MD. 1988.

10. Jacobs, Allen M. "Local Antibiotic Treatment of Soft Tissue and Bone Infection of the Foot and Ankle." The High Risk Foot in Diabetes Mellitus. Pages 421-441. Churchill-Livingston.

11. Jacobs, Allen M. "Postoperative Infections." Infectious Disease of the Lower Extremity. Pages 251-265. Williams and Wilkins, Baltimore, MD. 1991.

12. Jacobs, Allen M. "Surgical Management of Common Foot Infections." Infectious Disease of the Lower Extremity. Pages 347-363. Williams and Wilkins, Baltimore, MD. 1991.

13. Jacobs, Allen M. "The Enigma of the Insensitive Foot." Medical and Surgical Therapeutics of the Foot and Ankle: Manual of Podiatric Therapeutics. Pages 649-659. Williams and Wilkins, Baltimore, MD. 1992.

14. Jacobs, Allen M. and H.R. Protzel. "The Foot in Geriatric Medicine." Cowdry's Geriatrics. Manning Publishing Co. St. Louis, MO. 1992.

15. Jacobs, Allen M. "Electrical Stimulation of Bone Healing." Textbook of Podiatric Surgery. Williams and Wilkins, Baltimore, MD. 1992.

16. Jacobs, Allen M. "Venous Disorders." Vascular Disorders of the Lower Extremity.

17. Jacobs, Allen M. "Current Concepts in Bone Healing." Advances in Podiatric Medicine and Surgery. C.V. Mosby, Publishers. 1995.

ORIGINAL PUBLICATIONS - Videotaped Presentations:

1. "Radiographic Evaluation of Infections." PICA Risk Management Series, 1988.

2. "Early Diagnosis and Treatment of Infections." PICA Risk Management Series, 1988.

3. "Surgical Management of the Diabetic Foot." Vascular Diagnostic Corporation, 1980. Recipient of American Podiatric Medical Association Hall of Science First Place Award, Hollywood, Florida.

4. "Radionuclide Bone Imaging in Podiatry." National Podiatric Research and Training Center, St. Louis, MO, 1979.

5. "Radiographic Analysis of First Ray Deformities." Seminar on Cavus Foot Deformity, Pennsylvania College of Podiatric Medicine, 1976.

6. Surgical Management of Structural Hallux Abductus Deformity by Osteotomy and Compression Fixation with Miniature Bone Plates." Third Annual Surgical Seminar, Pennsylvania College of Podiatric Medicine, 1975.

7. "Radiologic Analysis of Cavus Foot Deformity." Seminar on Cavus Foot Deformity, Pennsylvania College of Podiatric Medicine, 1975.

8. "Sports Medicine Instructional Course Lecture." Washington University School of Medicine and Milliken Communications Corporation, 1979.

ORIGINAL PUBLICATIONS - Published Journal Articles:

1. "Multiple Enchodromatosis: A Case Report and Review of the Literature." Journal of Foot Surgery 13, 1974. Kaplan, Kaplan, Jacobs and Bean.

2. "Nosocomial Infections in Podiatric Surgery: An Analysis of Preoperative, Operative and Postoperative Factors." Journal of Foot Surgery 14, 1975. Kaplan, Kaplan and Jacobs.

3. "Biplane Osteotomy in the Correction of Fifth Metatarsal Head Lesions." Journal of Foot Surgery 14, 1975. Kaplan, Kaplan and Jacobs.

4. "Soft Tissue Tumors of the Foot." Journal of Foot Surgery 14, 1975. Berlin and Jacobs.

5. "Structural Hallux Abductus: Correction by Osteotomy and Fixation by Self-Compressing Bone Plates." Audio Journal of Podiatry, November, 1975. Jacobs.

6. "Hibbs Tenosuspension in the Treatment of Claw-Toe Deformity." Journal of Foot Surgery 14, 1975. Butlin and Jacobs.

7. "Triple Arthrodesis: A Review of Current Techniques." Journal of Foot Surgery 15, 1976. Kaplan, Kaplan and Jacobs.

8. "Limping in Children: An Etiologic Survey in Podiatric Practice." Audio Journal of Podiatry, March, 1976.

9. "Tarsal Tunnel Syndrome: Diagnosis and Surgical Management." Audio Journal of Podiatry, September, 1978.

10. "Professional Services Letter Defining the Determination of Clinical Privileges of Podiatrists." Veterans Administration Manual, October, 1978.

11. "Radiological Assessment and Diagnosis of Lateral Ankle Joint Injuries." Journal of Foot Surgery 19, (2) 1979. Downing, Oloff, Jacobs.

12. "Sports Medicine Review: The Lower Extremity." Instructional Computer Course Lectures. Milliken Communications and Washington University School of Medicine, 1980. Oloff, Jacobs.

13. "Lateral Ankle Joint Stabilization Techniques: Classification and Criteria." Journal of Foot Surgery 19, (2) 1980. Visser, Oloff, Jacobs.

14. "Calcaneal Osteotomy in the Management of Flexible Flatfoot Deformity: A Preliminary Report." Journal of Foot Surgery 20, (3) 1981. Oloff, Jacobs.

15. "Surgical Anatomy of the Lateral Ankle Joint Complex." Journal of Foot Surgery 20, (4) 1981. Klein, Oloff, Jacobs.

16. "Tarsal Coalitions in Rigid Flatfoot: An Instructional Course Lecture." Journal of Foot Surgery 21, (1) 1982. Jacobs, Oloff, Sollecito, Klein.

17. "Diabetic Autonomic Neuropathy in the Surgical Management of the Diabetic Foot." Journal of Foot Surgery 21, (1) 1982. Schustek, Jacobs.

18. "Elevated Temperature in the Postoperative Patient." Journal of Foot Surgery 21, (4) 1982. Drago, Jacobs, Oloff.

19. "A Comparative Study of Postoperative Care with Phenol Nail Procedures." Journal of Foot Surgery 22, (4) 1983. Drago, Jacobs, Oloff.

20. "Tarsal Tunnel Syndrome: A Manifestation of Systemic Diseases." Journal of Foot Surgery 22, (4) 1983. Oloff, Jacobs, Jaffe.

21. "The Utilization of Differential Scintigraphy in the Clinical Diagnosis of Osseous and Soft Tissue Changes Affecting the Diabetic Foot." Journal of Foot Surgery 23, (1) 1984. Visser, Jacobs, Oloff, Drago.

22. "Radionuclide Evaluation of Complications Following Metatarsal Osteotomy and Implant Arthroplasty of the Foot." Journal of Foot Surgery 23, (1) 1984. Jacobs, Klein, Oloff, Tuccio.

23. "Sickle Cell Anemia in Podiatric Surgery." Journal of Foot Surgery 23, (2) 1984. Caputi, Jacobs, Oloff.

24. "The Utilization of Radionuclide Bone and Joint Imaging in Arthritic and Related Disease." Journal of Foot Surgery 23, (2) 1984. Sollecito, Jacobs, Oloff, Soave, Bernstein.

25. "A Comprehensive Review of Hallux Limitus." Journal of Foot Surgery 23, (3) 1984. Jacobs, Amarnek, Oloff.

26. "Atypical Fibrosis Histocytoma of the Great Toe." Journal of Foot Surgery 23, (3) 1984. Jacobs, Amarnek, Oloff.

27. "Surgical Management of Forefoot Supinatus in Flexible Flatfoot Deformity." Journal of Foot Surgery 23, (5) 1984. Jacobs, Oloff.

28. "Rheumatoid Nodulosis in the Foot: A Variation of Rheumatoid Arthritis." Journal of Foot Surgery 23, (5) 1984. Jacobs, Oloff, Oloff-Soloman.

29. "Tenography in the Diagnosis of Tendon Disorders of the Foot and Ankle." Radiology, June, 1984. Gilula, Oloff, Jacobs, Caputi, Solomon, Destouet.

30. "Cysts and Cyst-Like Lesions of the Foot." Journal of Foot Surgery 24, (1) 1985. Bernstein, Jacobs, Oloff, Gilula.

31. "Adolescent Hallux Valgus: Its Etiology and Surgical Management." Journal of Foot Surgery 25, (1) 1986. Amarnek, Jacobs, Oloff.

32. "A Statistical Analysis of Reliability of the Proximal Articular Set Angle." Journal of Foot Surgery 25, (1) 1986. Amarnek, Mollica, Jacobs, Oloff.

33. "Reflex Sympathetic Dystrophy Syndrome." Journal of Foot Surgery 25, (2) 1986. Carlson, Jacobs.

34. "Non-Steroidal Anti-Inflammatory Drugs in Podiatric Medicine and Surgery." Journal of Foot Surgery 25, (3) 1986. Jacobs, Oloff, Williams.

35. Opening Base-Wedge Osteotomy of the First Metatarsal Utilizing Rigid External Fixation." Journal of Foot Surgery 25, (5) 1986. Amarnek, Juda, Oloff, Jacobs.

36. "Complications of Subtalar Arthroereisis." Journal of Foot Surgery 26, (2) 1987. Oloff, Naylor, Jacobs.

37. "Management of Osteomyelitis With The Utilization of Antibiotic Loaded Bone Cement." Podiatry Tracts 1, (2) 1988. Jacobs.

38. "Retrospective Analysis of the Long Term Effects of the Lisfranc's Fracture-Dislocations." Podiatry Tracts 1, (3) 1988. Jacobs.

39. "The Lapidus Procedure for Juvenile Bunion Deformity." Podiatry Tracts 1, (3) 1988. Jacobs.

40. "Impaired Vascular Response to Ischemia in Diabetic Patients. Podiatry Tracts 1, (3) 1988. Jacobs.

41. "Bone Scintigraphy and Radiography in the Early Detection of Diabetic Osteopathy." Podiatry Tracts 2, (2) 1989. Jacobs.

42. "Thermographic Evaluation of the Autonomic Effects of Nerve Blocks in the Foot." Journal of the American Podiatric Medical Association 79, (3) 1989. Jacobs.

43. "Autonomic Neuropathy in Diabetes Mellitus." Podiatry Tracts 2, (4) 1989. Jacobs.

44. "Bone and Joint Pathology in Diabetes Mellitus." Podiatry Tracts 2, (4) 1989. Jacobs.

45. "The Etiology of Hallux Valgus." Podiatry Tracts 2, (1) 1989. Jacobs.

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ORIGINAL PUBLICATIONS - Original Papers Prepared for Seminars and Scientific Meetings:

1. PRELIMINARY REPORT ON THE STATUS OF SELF COMPRESSING MINIATURE BONE PLATES IN THE SURGICAL MANAGEMENT OF STRUCTURAL HALLUS ABDUCTUS DEFORMITY
   Presented at Pennsylvania College of Podiatric Medicine Annual Surgical Seminar. Cherry Hill, NJ. September, 1975.

2. MODIFICATION OF THE MITCHELL BUNIONECTOMY FOR THE CORRECTION OF FIRST METATARSAL ARTICULAR ALTERATION
   Presented at Southern New Jersey Podiatry Society Scientific Meeting. Cherry Hill, NJ. October, 1975.

3. SURGICAL MANAGEMENT OF THE INTRACTABLE PLANTAR KERATOMA
   Presented at Philadelphia County Podiatry Society Scientific Meeting. Philadelphia, PA. May, 1976.

4. RADIOGRAPHIC EVALUATION OF FIRST RAY DEFORMITIES
   Presented at Pennsylvania College of Podiatric Medicine Diagnostic Foot Radiology Seminar. Philadelphia, PA. April, 1976.

5. METATARSUS ADDUCTUS: A LITERATURE REVIEW
   Presented at Southern New Jersey Podiatry Society Scientific Meeting. Cherry Hill, NJ. September, 1977.

6. DIFFERENTIAL DIAGNOSIS OF LIMPING IN CHILDREN
   Presented at Pennsylvania College of Podiatric Medicine Pediatric Orthopedic Seminar. Philadelphia, PA. October, 1976.

7. TARSAL COALITIONS: DIFFERENTIAL DIAGNOSIS OF THE RIGID VALGUS FOOT
   Presented at Southern New Jersey Podiatry Society Scientific Weekend. Cherry Hill, NJ. May, 1977.

8. CURRENT CONCEPTS IN PEDIATRIC ORTHOPEDICS WITH A SPECIAL EMPHASIS ON TRANSVERSE PLANE ABNORMALITIES OF THE LOWER EXTREMITY

1) Tarsal Tunnel Syndrome: Diagnosis and Management.

2) Tarsal Coalitions: Radiographic and Clinical Evaluation Techniques.

Presented at New Jersey Podiatry Society Scientific Sessions. Rutgers Medical College. New Brunswick, NJ. October, 1977.

9. RADIOGRAPHIC ANALYSIS OF CAVUS FOOT DEFORMITY

Presented at Pennsylvania College of Podiatric Medicine Diagnostic Foot Radiology Seminar. Philadelphia, PA. April, 1976.

10. ETIOLOGY OF CAVUS FOOT DEFORMITIES: A REVIEW OF NEUROMUSCULAR CONSIDERATIONS

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11. SURGICAL AND BIOMECHANICAL CONSIDERATIONS IN THE MANAGEMENT OF POSTERIOR CAVUS FOOT DEFORMITY

Presented at Washington Memorial Hospital Seminar on Cavus Foot Deformity. Turnersville, NJ. November, 1977.

12. A REVIEW OF IMPLANT ARTHROPLASTY TECHNIQUES IN THE MANAGEMENT OF BUNION DEFORMITY

Presented at New York State (Southern Tier) Podiatry Society. February, 1977.

13. SURGICAL MANAGEMENT OF METATARSUS ADDUCTUS

Presented at Atlantic County Podiatry Society Scientific Meeting. Pleasantville, NJ. April, 1977.

14. LIMPING IN CHILDREN

Presented at American Podiatry Association Region 3 Scientific Meeting. Cherry Hill, NJ. May, 1977.

15. RADIONUCLIDE BONE IMAGING IN THE EVALUATION OF FOOT PATHOLOGY

Presented at Pennsylvania College of Podiatric Medicine Surgical Seminar. Philadelphia, PA. October, 1978.

16. BIOMECHANICAL IMPLICATIONS AND SURGICAL MANAGEMENT OF HALLUX LIMITUS

Presented at Riverside Hospital Scientific Meeting. Farleigh Dickinson University, NJ. March, 1978.

17. BONE SCANNING IN THE EVALUATION OF PEDIATRIC FOOT DISORDERS
Presented at Scientific Weekend Massachusetts Podiatry Society, University of Massachusetts Medical School. Worcester, MA. April, 1978.

18. TOMOGRAPHIC EVALUATION OF THE SUBTALAR JOINT IN FLEXIBLE FLATFOOT DEFORMITY
Presented at Monsignor Clement Kern Hospital for Special Surgery, Surgical Seminar. Detroit, MI. May, 1978.

19. BIOMECHANICAL CONSIDERATIONS IN THE SURGICAL CORRECTION OF JUVENILE METATARSUS ADDUCTUS DEFORMITY
Presented at Monsignor Clement Kern Hospital for Special Surgery, Surgical Seminar. Detroit, MI. May, 1978.

20. BONE SCANNING IN PODIATRIC MEDICINE
Presented at Monsignor Clement Kern Hospital for special Surgery, Surgical Seminar. Detroit, MI. May, 1978.

21. TARSAL TUNNEL SYNDROME
Presented at Civic Hospital Resident Alumni Society 22nd Annual Scientific Meeting and Surgical Seminar. Tucson, AZ. May, 1978.

22. BIOMECHANICS OF FIRST METATARSOPHALANGEAL JOINT IMPLANT ARTHROPLASTY
Presented at Civic Hospital Resident Alumni Society 22nd Annual Scientific Meeting and Surgical Seminar. Tucson, AZ. May, 1978.

23. RADIONUCLIDE BONE IMAGING IN PODIATRIC MEDICINE
Presented at Civic Hospital Resident Alumni Society 22nd Annual Scientific Meeting and Surgical Seminar. Tucson, AZ. May, 1978.

24. RADIONUCLIDE BONE IMAGING IN PODIATRY
Presented at Southern Virginia Podiatry Society Scientific Meeting. Fairfax, VA. September, 1978.

25. RADIONUCLIDE BONE IMAGING IN PODIATRY: EVALUATION AND SURGICAL MANAGEMENT OF PEDIATRIC FLATFOOT, IN-TOED AND OUT-TOED GAIT IN CHILDREN AND EVALUATION/THERAPY/SURGICAL MANAGEMENT OF THE HIGH-ARCHED FOOT
Presented at Texas Podiatry Society "Day of Science". Dallas, TX. September, 1978.

26. METATARSUS ADDUCTUS: DIAGNOSIS, EVALUATION AND TREATMENT
Presented at Washington, D.C. Podiatry Society Scientific Meeting. Washington, D.C. September, 1978.

27. BONE SCANNING IN PODIATRY
Presented at Washington, D.C. Podiatry Society Scientific Meeting. Washington, D.C. October, 1978.

28. TARSAL TUNNEL SYNDROME AND ITS DIFFERENTIAL DIAGNOSIS
Presented at Pennsylvania College of Podiatric Medicine 5th Annual Surgical Conference, University of Pennsylvania Children's Hospital. Philadelphia, PA. October, 1978.

29. * DIAGNOSIS AND MANAGEMENT OF THE RIGID VALGUS FOOT
* RADIOLOGIC EVALUATION OF BUNION DEFORMITY
* METATARSAL OSTEOTOMIES: CURRENT SURGICAL TECHNIQUES
* EVALUATION OF THE PEDIATRIC PATIENT FOR TENDO-ACHILLES SURGICAL PROCEDURES
* RADIONUCLIDE BONE IMAGING IN PODIATRY
* EVALUATION AND MANAGEMENT OF SURGICAL COMPLICATIONS
* BIOMATERIALS IN FOOT SURGERY: AN OVERVIEW
Presented at Milton S. Hershey Medical School Faculty Scientific Meeting, Pennsylvania Podiatry Association Annual Surgical Seminar. Hershey, PA. November, 1978.

30. RADIONUCLIDE BONE IMAGING IN PODIATRY
Presented at Veterans Administration Scientific Chairperson at Regional Medical Education Center (RMEC), 1st National Conference on Podiatric Care of the Aging Veteran Patient. Washington, D.C. December, 1978.

31. * IMPLANT ARTHROPLASTY IN PODIATRIC SURGERY
* RADIONUCLIDE BONE IMAGING IN PODIATRY
Presented at Midwest Podiatry Conference Annual Meeting. Chicago, IL. April, 1978.

32. * IMPLANT ARTHROPLASTY IN PODIATRIC SURGERY
* RADIONUCLIDE BONE IMAGING IN PODIATRY
Presented at Indiana States Podiatry Society Annual Meeting, Notre Dame University. South Bend, IN. May, 1978.

33. RECENT ADVANCES IN PODIATRIC SURGERY

Presented at St. Louis Pharmacists' Society Meeting. St. Louis, MO. May, 1979.

34. HEEL PAIN: THE PODIATRIST'S VIEW
Presented at Washington University Medical School Rheumatology Department, Resident and Fellow Lecture Series. St. Louis, MO. May, 1979.

35. * MANAGEMENT OF DIABETIC FOOT INFECTIONS
* OSTEOTOMY OF THE TIBIA FOR THE CORRECTION OF ANKLE VALGUS
* BASIC SOFT TISSUE FLAPS IN THE MANAGEMENT OF SOFT TISSUE MASSES OF THE PLANTAR ARCH
Presented at Civic Hospital Resident Alumni Society 23rd Annual Scientific Meeting. Egland AFB, FL. 1979.

36. EVALUATION OF PERIPHERAL NEUROPATHIES AFFECTING THE LOWER EXTREMITY
Presented at American Podiatry Association Annual Scientific Meeting. Detroit, MI. August, 1979.

37. * SURGICAL TECHNIQUES FOR ACHILLES TENDON LENGTHENING
* SURGICAL RECONSTRUCTION OF THE FLEXIBLE FLATFOOT
* RADIOGRAPHIC EVALUATION OF FLATFOOT DEFORMITY
Presented at Monsignor Clement Kern Hospital for Special Surgery, Surgical Seminar. Detroit, MI. August, 1979.

38. IMPLANTS AND BIOMATERIALS
Presented at Missouri State Podiatry Society Annual Meeting. Lake of the Ozarks, MO. August, 1979.

39. PODIATRIC CARE IN EXTENDED CARE FACILITIES: SOME GUIDELINES
Presented to Missouri Catholic Association of Homes for the Aged. St. Louis, MO. August, 1979.

40. * IMPLANTS AND BIOMATERIALS
* RADIOLOGIC EVALUATION OF RHEUMATOID ARTHRITIS IN THE FOOT
* HEEL PAIN AND THE SPONDYLOARTHROPATHIES: CLINICAL AND RADIOLOGIC EVALUATION
* GOUT AND PSEUDOGOUT: DIAGNOSIS AND MANAGEMENT OF PEDAL SEQUELAE
* TARSAL TUNNEL SYNDROME
Presented at Milwaukee Podiatry Society Scientific Meeting. Milwaukee, WI. October, 1979.

41. * CURRENT SURGICAL TECHNIQUES IN THE MANAGEMENT OF

COMMON DIGITAL DEFORMITIES
* SURGICAL MANAGEMENT OF THE INGROWN NAIL: CURRENT METHODOLOGY
* RADIOLOGIC EVALUATION OF LOWER EXTREMITY FRACTURES
* MANAGEMENT OF COMPLICATIONS FOLLOWING METATARSAL OSTEOTOMIES
* BIOCHEMICAL AND BIOPHYSICAL CONSIDERATIONS IN THE UTILIZATION OF STAINLESS STEEL IMPLANTS IN FOOT SURGERY
* RADIOGRAPHIC AND CLINICAL EVALUATION OF THE PEDAL ARTHRIDITIES
* RADIONUCLIDE BONE IMAGING IN PODIATRY
* EVALUATION AND MANAGEMENT OF DIGITAL AND METATARSAL TRAUMA

Presented at Milton S. Hershey Medical School Faculty Scientific Meeting. Pennsylvania Podiatry Association Annual Surgical Seminar. Hershey, PA. November, 1979.

42. * EVALUATION AND MANAGEMENT OF TARSAL TUNNEL SYNDROME
* RADIONUCLIDE BONE IMAGING IN PODIATRY

Presented at Connecticut State Podiatry Society Annual Seminar. New Haven, CT. December, 1979.

43. IMPLANT ARTHROPLASTY IN THE MANAGEMENT OF PEDAL OSTEOARTHRITIS

Presented at St. Louis Pharmacists' Society Meeting. St. Louis, MO. January, 1980.

44. * SILASTIC IMPLANT ARTHROPLASTY IN RECONSTRUCTIVE SURGERY OF THE FOOT: CURRENT METHODOLOGY AT LINDELL HOSPITAL
* PHYSICAL AND BIOCAMPATIBILITY PROPERTIES OF STAINLESS STEEL, COBALT AND TITANIUM ALLOY IMPLANTS (AISI 316 LVM) IN FOOT SURGERY
* BIOMECHANICALLY-INDUCED OSTEOARTHRITIS OF THE FIRST METATARSOPHALANGEAL JOINT: CLINICAL AND RADIOGRAPHIC EVALUATION

Presented at North Carolina State Podiatry Society Annual Surgical Seminar. Charlotte, NC. January, 1980.

45. * LOWER EXTREMITY MANIFESTATIONS OF ADULT AND JUVENILE RHEUMATOID ARTHRITIS
* LOWER EXTREMITY RECONSTRUCTIVE SURGERY AND PERIOPERATIVE MANAGEMENT OF GOUT AND RHEUMATOID ARTHRITIS

Presented at Civic Hospital Resident Alumni Society 24th Annual

Surgical Seminar. Phoenix, AZ. May, 1980.

46. * EVALUATION AND SURGICAL MANAGEMENT OF THE DIABETIC FOOT WITH SPECIAL REFERENCE TO THE CONTROL OF INFECTIOUS DISEASE
* RADIONUCLIDE BONE IMAGING IN PODIATRY
* LOWER EXTREMITY MANIFESTATIONS OF THE SERONEGATIVE SPONDYLOARTHROPATHIES

Presented at New Mexico State Podiatry Society Annual Surgical Seminar. Albuquerque, NM. July, 1980.

47. * RADIONUCLIDE BONE IMAGING IN PODIATRY
* SURGICAL MANAGEMENT OF THE DIABETIC FOOT
* IMPLANTS AND BIOMATERIALS WITH SPECIAL REFERENCE TO THE UTILIZATION OF POLYMETRIC IMPLANTS IN THE MANAGEMENT OF HALLUX LIMITUS

Presented at Northwestern Ohio Podiatry Academy. Toledo, OH. January, 1981.

48. * SURGICAL MANAGEMENT OF ULCERATIONS AND INFECTIONS IN THE DIABETIC FOOT WITH SPECIAL REFERENCE TO THE CLINICAL VASCULAR ASSESSMENT
* CALCANEAL OSTEOTOMY IN THE MANAGEMENT OF FLEXIBLE FLATFOOT
* RADIONUCLIDE BONE IMAGING IN PODIATRY WITH SPECIAL REFERENCE TO THE EVALUATION OF HEALING IMPLANT SURGERIES AND METATARSAL OSTEOTOMIES

Presented at New York State Podiatry Society Annual Scientific Meeting. New York, NY. March, 1981.

49. * RADIOGRAPHIC EVALUATION OF GOUTY ARTHRITIS
* ADULT AND JUVENILE RHEUMATOID ARTHRITIS AND JUVENILE ANKYLOSING SPONDYLITIS IN THE LOWER EXTREMITIES

Presented at the American College of Chiropractic Radiologist Annual Scientific Meeting. St. Louis, MO. March, 1981.

50. * DIFFERENTIAL SCINTIGRAPHY IN THE EVALUATION FO DIABETIC OSTEOLYSIS, OSTEOMYELITIS AND CHARCOT JOINT DISEASE
* THALLIUM 201 SCINTIGRAPHY IN THE EVALUATION OF THE HEALING POTENTIAL OF LOWER EXTREMITY DIABETIC ULCERATION AND CORRELATION WITH XENON 133 CLEARANCE STUDIES
* CALCANEAL OSTEOTOMY IN THE MANAGEMENT OF FLATFOOT DEFORMITY WITH SPECIAL REFERENCE TO FOREFOOT SUPINATUS

DEFORMITY
* LATERAL ANKLE JOINT STABILIZATION TECHNIQUES: CURRENT METHODOLOGY AT LINDELL HOSPITAL
* SURGICAL MANAGEMENT OF DIABETIC FOOT ULCERATIONS AND INFECTIONS

Presented at Civic Hospital Resident Alumni Society 25th Annual Surgical Seminar. Detroit, MI. May, 1981.

51. * CALCANEAL OSTEOTOMY IN THE MANAGEMENT OF FLATFOOT DEFORMITY
* STJ SILASTIC ARTHROEREISIS AND THE HOKE PROCEDURE IN THE MANAGEMENT OF MEDIAL INSTABILITY IN FLATFOOT DEFORMITY
* EVALUATION AND MANAGEMENT OF RIGID FLATFOOT DEFORMITY WITH SPECIAL REFERENCE TO TARSAL COALITIONS
* EVALUATION AND MANAGEMENT OF TARSAL TUNNEL SYNDROME
* LOWER EXTREMITY MANIFESTATIONS OF THE SERONEGATIVE SPONDYOARTHROPATHIES WITH SPECIAL REFERENCE TO REITER'S SYNDROME, PSORIATIC ARTHRITIS AND ANKYLOSING SPONDYLITIS
* SURGICAL MANAGEMENT OF INFECTION AND ULCERATIONS IN THE DIABETIC PATIENT
* RADIONUCLIDE BONE IMAGING AND DIFFERENTIAL SCINTOGRAPHY IN PODIATRY WITH SPECIAL REFERENCE TO THE DIABETIC FOOT

Presented to Ohio College of Podiatric Medicine Pi Delta National Honor Society Scientific Weekend Seminar. Cleveland, OH. May, 1981.

52. PSORIATIC ARTHRITIS AND REITER'S SYNDROME: A REVIEW WITH SPECIAL EMPHASIS ON PODIATRIC MANIFESTATIONS

Presented to Missouri State Podiatry Society Annual Meeting and Seminar. September, 1981.

53. * RADIONUCLIDE AND RADIOGRAPHIC EVALUATION OF THE DIABETIC FOOT
* CLINICAL LABORATORY AND RADIOGRAPHIC EVALUATION OF INFLAMMATORY RHEUMATIC DISEASE

Presented to American Podiatric Medical Association Region 14 Annual Scientific Seminar. Denver, CO. September, 1981.

54. BIOMECHANICALLY INDUCE OSTEOARTHRITIS IN THE FOOT

Presented to St. Louis Rheumatism Society. St. Louis, MO. February, 1982.

55. BIOMATERIAL AND BIOPHYSICS OF PEDAL IMPLANT

ARTHROPLASTY/LESSER MPJ IMPLANT ARTHROPLASTY

Presented at American College of Foot Surgeons Annual Meeting and Scientific Seminar. Houston, TX. February, 1982.

56. * JUVENILE BUNION DEFORMITY: CURRENT TECHNIQUES IN MANAGEMENT
* JUVENILE CAVUS FOOT DEFORMITY: EVALUATION AND MANAGEMENT

Presented to Suburban Hospital Association Symposium on Congenital and Early Childhood Defects of the Lower Extremity. Washington, D.C. March, 1982.

57. * EVALUATION AND MANAGEMENT OF TRANSVERSE PLANE FLATFOOT DEFORMITY
* SURGICAL RECONSTRUCTION OF ARTHRITIS JOINTS

Presented at Midwest Podiatry Conference. Chicago, IL. April, 1982.

58. * RADIOGRAPHIC AND VASCULAR EVALUATION OF THE DIABETIC FOOT
* RADIOGRAPHIC EVALUATION OF SOLITARY BONE LESIONS OF THE FOOT
* RADIONUCLIDE EVALUATION OF COMPLICATIONS OF IMPLANTS

Presented to Civic Hospital Resident Alumni Society 26th Annual Surgical Seminar. Sarasota, FL. May, 1982.

59. * MEDICAL MANAGEMENT OF THE ARTHRITIS PATIENT
* RADIONUCLIDE EVALUATION OF COMPLICATIONS IN THE POSTOPERATIVE PATIENT
* NSAID'S IN PODIATRIC MEDICINE AND SURGERY
* SURGICAL MANAGEMENT OF FLATFOOT DEFORMITY BY CALCANEAL OSTEOTOMY

Presented at Western New York State Podiatry Society Scientific Meeting. Buffalo, NY. October, 1982.

60. * EVALUATION OF DIABETIC NEUROPATHY
* SURGICAL MANAGEMENT OF THE DIABETIC FOOT
* RADIOGRAPHIC EVALUATION OF THE COMPLICATIONS OF METATARSAL OSTEOTOMIES AND IMPLANTS
* SURGICAL MANAGEMENT OF FLATFOOT DEFORMITY

Presented at Western Pennsylvania Podiatry Society Annual Scientific Meeting. Pittsburgh, PA. October, 1982.

61. * SURGICAL MANAGEMENT OF THE ARTHRITIC PATIENT

* ACUTE AND CHRONIC COMPLICATIONS OF IMPLANT ARTHROPLASTY
* NSAID'S IN PODIATRIC MEDICINE AND SURGERY
* SURGICAL MANAGEMENT OF FLEXIBLE AND NON-FLEXIBLE FLATFOOT DEFORMITY

Presented at Monsignor Clement Kern Hospital for Special Surgery Surgical Seminar. Warren, MI. November, 1982.

62. MEDICAL AND SURGICAL MANAGEMENT OF THE ARTHRITIC PATIENT

Presented at William School College of Podiatric Medicine. Chicago, IL. November, 1982.

63.
* FEVER IN THE POSTOPERATIVE PATIENT
* LONG TERM COMPLICATIONS OF IMPLANT ARTHROPLASTY
* COMPLICATIONS IN THE SURGICAL MANAGEMENT OF THE ARTHRITIC PATIENT
* PROPHYLACTIC ANTIBIOTICS IN FOOT SURGERY
* BONE SCANNING IN THE EVALUATION OF COMPLICATIONS OF IMPLANT SURGERY AND OSTEOTOMIES OF THE FOOT
* COMPLICATIONS OF FLATFOOT SURGERY

Presented at Northwestern Ohio Podiatry Society Symposium on Complications in Foot Surgery. Toledo, OH. February, 1983.

64.
* SURGICAL MANAGEMENT OF THE ARTHRITIC PATIENT
* BONE SCANNING IN THE EVALUATION OF COMPLICATIONS OF IMPLANT SURGERY AND OSTEOTOMIES OF THE FOOT
* LONG TERM COMPLICATIONS OF IMPLANT ARTHROPLASTY
* NSAID'S IN PODIATRIC MEDICINE AND SURGERY

Presented at New York State Podiatry Society Annual Scientific Meeting. March, 1983.

65. NSAID'S IN PODIATRIC MEDICINE AND SURGERY

Presented at Civic Hospital Resident Alumni Society 27th Annual Surgical Seminar. Cancun, Mexico. April, 1983.

66.
* DIFFERENTIAL DIAGNOSIS OF SERONEGATIVE RHEUMATOID ARTHRITIC VARIANTS
* SELECTION OF APPROPRIATE NSAID DRUGS
* SURGICAL TREATMENT OF ARTHRITIC PATIENTS

Presented at American College of Foot Surgeons Western Division Annual Surgical Seminar. Monterey, CA. May, 1983.

67. * BONE SCANNING IN THE EVALUATION OF COMPLICATIONS OF IMPLANT SURGERIES AND OSTEOTOMIES OF THE FOOT

* LONG TERM COMPLICATIONS OF IMPLANT ARTHROPLASTY
* SURGICAL MANAGEMENT OF THE ARTHRITIC PATIENT
* MANAGEMENT OF FLEXIBLE FLATFOOT DEFORMITY

Presented at American Podiatric Medical Association Annual Scientific Meeting. Boston, MA. August, 1983.

68. * EVALUATION AND MANAGEMENT OF FEVER IN THE POSTOPERATIVE PATIENT
* CT SCANNING IN THE EVALUATION OF FOOT PATHOLOGY: DELAYED UNION, NON-UNION AND PSEUDOARTHRITIS RECOGNITION AND MANAGEMENT
* MECHANISMS OF ANKLE JOINT FRACTURES

Presented at William Scholl College of Podiatric Medicine 6th Annual Alumni Meeting. Chicago, IL. September, 1983.

69. ETIOLOGY OF CAVUS FOOT DEFORMITY

Presented at Pennsylvania College of Podiatric Medicine Continuing Education Seminar. Philadelphia, PA. February, 1984.

70. * PODIATRIC METALLURGY
* IMPLANT ARTHROPLASTY OF THE FOOT
* TENDON TRANSFERS FOR CAVUS FOOT DEFORMITIES
* CT SCANNING OF THE FOOT AND ANKLE

Presented at Ohio College of Podiatric Medicine SNPA Annual Seminar. Cleveland, OH. February, 1984.

71. * CLINICAL AND HISTOLOGIC CORRELATIONS OF GAP BONE HEALING
* EARLY RECOGNITION AND MANAGEMENT OF POSTOPERATIVE INFECTIONS
* IMPLANT ARTHROPLASTY FOR LESSER TOES

Presented at American College of Foot Surgeons Annual Scientific Meeting. Las Vegas, NV. February, 1984.

72. * CALCANEAL OSTEOTOMY IN THE SURGICAL MANAGEMENT OF FLEXIBLE FLATFOOT DEFORMITY
* MEDICAL COLUMN STABILIZATION PROCEDURE: SUBTALAR JOINT IMPLANT

Presented at Texas Podiatry Society Annual Scientific Meeting. San Antonio, TX. March, 1984.

73. SURGICAL AND NON-SURGICAL MANAGEMENT OF THE ARTHRITIC FOOT

Presented at Washington University School of Medicine Department of Rheumatology Meeting. April, 1984.

74. PREOPERATIVE EVALUATION OF COAGULOPATHIES
Presented at Midwest Podiatry Society Scientific Meeting. Chicago, IL April, 1984.

75. NSAID'S AND THEIR APPLICATION IN PODIATRIC MEDICINE
Presented at Civic Hospital Resident Alumni Society 28th Annual Surgical Seminar. Sarasota, FL. May, 1984.

76. * PRINCIPLES IN EVALUATION OF POSTOPERATIVE BONE HEALING
* FEVER IN POSTOPERATIVE PATIENTS
* RECOGNITION AND MANAGEMENT OF DELAYED UNION AND NON-UNION
Presented at American Podiatric Medical Association Region 8 annual Scientific Meeting. Norfolk, VA. May, 1984.

77. * SURGICAL MANAGEMENT OF FLEXIBLE AND RIGID FLATFOOT DEFORMITY
* COMPLICATIONS OF IMPLANT ARTHROPLASTY
Presented at Michigan State Podiatry Society Annual Scientific Session. Flint, MI. September, 1984.

78. * SURGICAL MANAGEMENT OF FLEXIBLE FLATFOOT DEFORMITY IN THE ADULT PATIENT
* NON-OPERATIVE MANAGEMENT OF THE ARTHRITIC PATIENT
* MANAGEMENT OF COMMON PODIATRIC INFECTIONS
Presented at American College of Foot Surgeons Western New York Division Scientific Meeting. Buffalo, NY. September, 1984.

79. * AUTONOMIC NEUROPATHY IN THE DIABETIC FOOT
* CT SCANNING OF THE FOOT AND ANKLE
* RADIOGRAPHIC EVALUATION OF THE DIABETIC FOOT
Presented at American Podiatric Medical Association Region 1 Annual Scientific Meeting. Newton, MA. October, 1984.

80. * ORAL MEDICATIONS IN THE TREATMENT OF THE ARTHRITIC FOOT
* OFFICE EVALUATION OF THE SERONEGATIVE ARTHRIDITIES
* SURGICAL MANAGEMENT OF THE RHEUMATOID FOOT
* RADIOGRAPHIC EVALUATION OF COMMON ARTHRITIC DEFORMITIES OF THE FOOT AND ANKLE
Presented at Ohio Podiatric Society Scientific Meeting. Cincinnati, OH. December, 1984.

81. HOSPITAL PROTOCOL FOR CHIROPRACTIC PHYSICIANS
Presented at Ohio Chiropractic Association Scientific Meeting.

Toledo, OH. November, 1984.

82. RADIOGRAPHIC EVALUATION OF THE DIABETIC FOOT
Presented at University of Texas Health Sciences Center Diabetic Foot Symposium. San Antonio, TX. December, 1984.

83. * ORAL MEDICATIONS IN THE TREATMENT OF THE ARTHRITIC FOOT
* OFFICE EVALUATION OF THE SERONEGATIVE ARTHRIDITIES
* SURGICAL MANAGEMENT OF THE RHEUMATOID FOOT
* RADIOGRAPHIC EVALUATION OF THE COMMON ARTHRITIC DEFORMITIES OF THE FOOT AND ANKLE
Presented at Southern Florida Podiatry Society Scientific Meeting. Boynton Beach, FL. December, 1984.

84. * SURGICAL MANAGEMENT OF JUVENILE BUNION DEFORMITY
* SURGICAL MANAGEMENT OF FLATFOOT DEFORMITY IN THE PEDIATRIC PATIENT
* ORAL MEDICATION IN THE TREATMENT OF ARTHRITIC DISEASE OF THE FOOT AND ANKLE
Presented at Pittsburgh Podiatry Hospital Scientific Sessions. Pittsburgh, PA. January, 1985.

85. * CT SCANNING OF THE FOOT AND ANKLE
* COMPLICATIONS OF IMPLANT ARTHROPLASTY
* SURGICAL MANAGEMENT OF THE ARTHRITIC FOOT
Presented at British Columbia Podiatry Society Annual Scientific Meeting. Vancouver, British Columbia, CANADA. February, 1985.

86. EVALUATION AND MANAGEMENT OF POSTOPERATIVE COMPLICATIONS
Presented at American College of Foot Surgeons Scientific Seminar. Tampa, FL, 1985.

87. * NEUROPATHY IN THE DIABETIC FOOT
* ORAL MEDICATIONS IN THE MANAGEMENT OF THE ARTHRITIC FOOT
* INFECTIONS AND INFECTION-LIKE DISORDERS OF THE DIABETIC FOOT
Presented at American Podiatric Medical Association Region 1 Annual Scientific Meeting. Boston, MA. March, 1985.

88. * EVALUATION AND MANAGEMENT OF POSTOPERATIVE COMPLICATIONS
* SURGICAL MANAGEMENT OF THE DIABETIC FOOT (PARTS I and II)

* ANTIBIOTIC SELECTION FOR POSTOPERATIVE INFECTION
Presented at William Scholl College of Podiatric Medicine Annual Alumni Scientific Meeting. Chicago, IL. March, 1985.

89. * ORAL MEDICATIONS IN THE TREATMENT OF THE ARTHRITIC FOOT
* SURGICAL MANAGEMENT OF THE RHEUMATOID FOOT
* RADIOGRAPHIC EVALUATION OF THE DIABETIC FOOT
Presented at American Podiatric Medical Association Region 7 Annual Scientific Meeting. Tacoma, WA. April, 1985.

90. * ORAL MEDICATIONS IN THE TREATMENT OF THE ARTHRITIC FOOT
* SURGICAL MANAGEMENT OF THE PRERHEUMATOID FOOT
* OFFICE EVALUATION OF THE SERONEGATIVE SPONDYLOARTHROPATHIES
* RADIOGRAPHIC EVALUATION OF COMMON ARTHRITIC DEFORMITIES OF THE FOOT AND ANKLE
Presented at Scientific Meeting. West Palm Beach, FL. April, 1985.

91. * CT SCANNING AND MRI OF THE FOOT AND ANKLE
* ORAL MEDICATIONS IN THE TREATMENT OF THE ARTHRITIC FOOT
* COMPLICATIONS OF IMPLANT ARTHROPLASTY
Presented at Oklahoma Podiatry Society Annual Scientific Session. Shangri-La, OK. May, 1985.

92. * ORAL MEDICATIONS IN THE TREATMENT OF THE ARTHRITIC FOOT
* OFFICE EVALUATION OF THE SERONEGATIVE SPONDYLOARTHROPATHIES
* RADIOGRAPHIC EVALUATION FO COMMON ARTHRITIC DEFORMITIES OF THE FOOT AND ANKLE
Presented at University of Massachusetts Medical School. March, 1985.

93. * SURGICAL MANAGEMENT OF THE ARTHRITIC FOOT
* CT SCANNING OF THE FOOT
Presented at Rochester, New York. Scientific Meeting. March, 1985.

94. SURGICAL MANAGEMENT OF THE ARTHRITIC FOOT
Presented at William Scholl College of Podiatric Medicine Scientific Meeting. Chicago, IL. June, 1985.

95. * SURGICAL MANAGEMENT OF FLATFOOT DEFORMITY
* SURGICAL MANAGEMENT OF HALLUX RIGIDUS

* SURGICAL MANAGEMENT OF THE ARTHRITIC FOOT

Presented at Monsignor Clement Kern Hospital for Special Surgery Residency Lecture Series. Detroit, MI. June, 1985.

96. COMPLICATIONS OF RIGID INTERNAL FIXATION

Presented at Missouri State Podiatry Society Annual Scientific Meeting.

97. * EVALUATION AND MANAGEMENT OF THE DIABETIC FOOT INFECTION
* PERIOPERATIVE SURGICAL MANAGEMENT OF THE DIABETIC FOOT

Presented at American Podiatric Medical Association Region 1 Annual Scientific Meeting. Boston, MA. October, 1985.

98. * ORAL MEDICATION IN THE TREATMENT OF THE ARTHRITIC FOOT
* OFFICE EVALUATION OF THE SERONEGATIVE SPONDYLOARTHROPATHIES
* SURGICAL MANAGEMENT OF THE RHEUMATOID FOOT
* SURGICAL MANAGEMENT OF THE DIABETIC FOOT

Presented at Arkansas Podiatric Society. Hot Springs, AR.

99. * RADIOGRAPHIC RELIABILITY IN EVALUATION OF HALLUX ABDUCTOVALGUS DEFORMITY
* SURGICAL MANAGEMENT OF HALLUX LIMITUS

Presented at American Podiatric Medical Association Region 3 37th Annual Scientific Meeting. Atlantic City, NJ. May, 1986.

100. * HYPERURICEMIA AND GOUT
* SURGICAL MANAGEMENT OF THE ARTHRITIC PATIENT
* SURGICAL MANAGEMENT OF HALLUX LIMITUS AND OSTEOARTHRITIS OF THE FIRST METATARSOPHALANGEAL JOINT
* LABORATORY EVALUATION OF THE ARTHRITIC PATIENT
* UTILIZATION OF NSAID DRUGS IN PODIATRIC MEDICINE

Presented at Missouri Podiatric Medical Association Scientific Meeting. Lake of the Ozarks, MO. May, 1986.

101. * EVALUATION AND MANAGEMENT OF INFLAMMATORY ARTHRITIS AFFECTING THE FOOT AND ANKLE
* SURGICAL MANAGEMENT OF THE ARTHRITIC FOOT
* THE USE AND ABUSE OF NON-STEROIDAL ANTI-INFLAMMATORY DRUGS

Presented at Maine Podiatric Association Scientific Meeting. York Harbor, ME. May/June, 1986.

102. * MANAGEMENT OF HALLUX LIMITUS BY APPLICATION OF RIGID INTERNAL FIXATION TO COMMONLY PERFORMED OSTEOTOMIES
* USE OF ANTIBIOTIC-LOADED BONE CEMENT IN THE TREATMENT OF OSTEOMYELITIS
* COMPLICATIONS OF IMPLANT ARTHROPLASTY

Presented at William Scholl College of Podiatric Medicine 8th Annual Surgical Seminar. Chicago, IL. June, 1985.

103. LONG TERM REACTION OF THE BODY TO PARTICULATE SHARDS FROM POLYMETRIC IMPLANTS OF THE FOOT AND ANKLE

Presented at American Podiatric Medical Association Annual Meeting Scientific Lecture Program. San Antonio, TX. August, 1986.

104. APPLICATIONS OF CT AND MRI SCANNING IN THE EVALUATION OF FOOT AND ANKLE DEFORMITIES

Presented at Illinois Podiatric Medical Association Annual Scientific Meeting. September, 1986.

105. * UTILIZATION OF ANTIBIOTIC-LOADED BONE CEMENT IN THE MANAGEMENT OF SOFT-TISSUE INFECTIONS
* USE OF ORAL ANTIBIOTICS IN THE TREATMENT OF COMMONLY ENCOUNTERED PODIATRIC INFECTIONS
* EVALUATION AND MANAGEMENT OF INFECTED IMPLANT AND OSTEOTOMY SURGERY

Presented at Missouri State Podiatric Association Scientific Meeting. Kansas City, MO. September, 1986.

106. * HYPERURICEMIA AND GOUT
* SURGICAL MANAGEMENT OF THE ARTHRITIC PATIENT
* SURGICAL MANAGEMENT OF HALLUX LIMITUS AND OSTEOARTHRITIS OF THE FIRST METATARSOPHALANGEAL JOINT
* LABORATORY EVALUATION OF THE ARTHRITIC PATIENT
* UTILIZATION OF NSAID DRUGS IN PODIATRIC MEDICINE

Presented at Connecticut Podiatric Association Scientific Meeting. Trumbull, CT. December, 1986.

107. * EVALUATION AND MANAGEMENT OF DIABETIC FOOT INFECTIONS
* USE OF ANTIBIOTIC-LOADED BONE CEMENT IN THE TREATMENT OF SOFT TISSUE AND OSSEOUS INFECTIONS OF THE FOOT
* SURGICAL MANAGEMENT OF HALLUX LIMITUS AND RIGIDUS

Presented at American Podiatric Medical Association Region 1 Scientific Meeting. Boston, MA. October, 1986.

108. EVALUATION OF HEEL PAIN WITH PARTICULAR REFERENCE TO THE

SERONEGATIVE SPONDYLOARTHROPATHIES
Presented at Arkansas Scientific Meeting. December, 1986.

109. * USAGE OF ANTIBIOTIC IMPREGNATED BONE CEMENT IN OSTEOMYELITIS
* SURGICAL AND NON-SURGICAL TREATMENT OF INFLAMMATORY ARTHRITIC FOOT DEFORMITIES
* CT SCANNING AND MRI OF HALLUX LIMITUS AND RIGIDUS
Presented at Utah Podiatry Association Scientific Seminar. Snowbird Ski Resort. Salt Lake City, UT. January, 1987.

110. SPORTS INJURIES: PREVENTION AND TREATMENT
Presented at St. Louis Science Center Meeting. St. Louis, MO. January, 1987.

111. * RADIOLOGIC AND DIAGNOSTIC EVALUATION OF TUMORS
* SURGICAL COMPLICATIONS IN NERVE LESIONS PROCEDURES
Presented at Podiatric Pathology Laboratories Fund for Podiatry Education and Research. Bahai Mar Resort and Yachting Center. Fort Lauderdale, FL. March, 1987.

112. * UTILIZATION OF ADVANCED RADIOGRAPHIC AND SCINTIGRAPHIC TECHNIQUES IN THE DIAGNOSIS OF FOOT PATHOLOGY
* MANAGEMENT OF DIABETIC FOOT INFECTIONS WITH SPECIAL REFERENCE TO ANTIBIOTIC-LOADED BONE CEMENT
* SURGICAL AND NON-SURGICAL MANAGEMENT OF INFLAMMATORY ARTHRITIS AFFECTING THE FOOT
* CURRENT METHODOLOGY AND PROBLEMS IN THE MANAGEMENT OF SYMPTOMATIC FLEXIBLE FLATFOOT DEFORMITY
* NEW APPROACHES IN THE MANAGEMENT OF PERIPHERAL NERVE INJURIES OF THE FOOT AND ANKLE
Presented at St. Vincent's Hospital Division of Podiatry, Department of Orthopedics Foot Symposium. Worcester, MA. March, 1987.

113. USE OF NON-STEROIDAL ANTI-INFLAMMATORY DRUGS IN PODIATRIC MEDICINE
Presented at Hillsboro County Podiatric Association Scientific Meeting. Tampa, FL. March, 1987.

114. THE ARTHRITIC FOOT
Presented at Scientific Meeting. Sarasota, FL. March, 1987.

115. RHEUMATOLOGY ENCOUNTERED IN PODIATRIC PRACTICE
Presented at Scientific Meeting. Cape Coral, FL. March, 1987.

116. * NERVE INJURIES AND POST-TRAUMATIC SYNDROMES
* USE OF CT SCANNING AND MRI WITH SOFT TISSUE INJURIES
Presented at ACFO/ACFS/Midwest Podiatric Conference Joint Scientific Seminar. Chicago, IL. April, 1987.

117. * LESSER METATARSAL OSTEOTOMIES
* CONGENITAL DEFORMITIES
* PLANTARFLEXED FIRST METATARSAL
* SURGICAL AND MEDICAL COMPLICATIONS
* JOINT REPLACEMENT ARTHROPLASTY
Presented at Midwest Podiatry Conference Board Review Instructional Courses. Chicago, IL. April, 1987.

118. BASIC REARFOOT SURGERY
Presented at Midwest Podiatry Conference Scientific Meeting. Chicago, IL. April, 1987.

119. * USE OF ANTIBIOTIC-IMPREGNATED BONE CEMENT IN THE TREATMENT OF OSTEOMYELITIS
* HALLUX LIMITUS: SURGICAL MANAGEMENT AND POSTOPERATIVE REHABILITATION
Presented at Podiatry Hospital of Pittsburgh Residents' Lecture Series. Pittsburgh, PA. May, 1987.

120. * ESSENTIAL SURGICAL TECHNIQUE (FOR OR, SCRUB TECHNICIANS)
* HEEL PAIN
* FOOT INFECTIONS
* THE DIABETIC FOOT IN PODIATRIC MEDICINE
Presented at Ohio Podiatric Medical Association Annual Scientific Meeting. Columbus, OH. May, 1987.

121. UTILIZATION OF NSAID'S IN PODIATRIC MEDICINE AND SURGERY
Presented from Midwest Podiatry Education Group, Inc. Darien, IL and Naperville, IL. June, 1987.

122. BONE AND JOINT CHANGES IN THE ARTHRITIC FOOT AND IN THE DIABETIC FOOT (CHARCOT JOINT)
Presented at American Podiatric Medical Association 75th Annual Scientific Meeting. Washington, D.C. August, 1987.

123. * SURGICAL MANAGEMENT OF FOOT DEFORMITY ASSOCIATED WITH INFLAMMATORY ARTHRITIS
* MANAGEMENT APPROACHES TO FIRST MPJ OSTEOARTHRITIS

* MANAGEMENT OF REFLEX SYMPATHETIC DYSTROPHY SYNDROME AND CHRONIC PAIN SYNDROMES OF THE FOOT AND ANKLE
* ESSENTIAL MEDICOLEGAL ASPECTS OF PODIATRIC SURGERY FOR PHYSICIANS' ASSISTANTS

Presented at Missouri Podiatric Medical Association Scientific Meeting. Omni Hotel. St. Louis, MO. September, 1987.

124. * HEEL PAIN
* OFFICE EVALUATION OF THE ARTHRITIC PATIENT
* ANTIBIOTIC-LOADED BONE CEMENT FOR OSTEOMYELITIS

Presented at American College of Foot Surgeons Regional Scientific Seminar. Buffalo, NY. September, 1987.

125. COMPLICATIONS IN FOOT SURGERY

Presented at Iowa College of Podiatric Medicine, Guest Lecture Series. Des Moines, IA. October, 1987.

126. * RADIOGRAPHIC, SCINTIGRAPHIC, COMPUTED TOMOGRAPHIC AND MAGNETIC RESONANCE IMAGED STUDIES IN EVALUATION OF THE NATURE AND EXTENT OF FOOT AND ANKLE INFECTION
* DIAGNOSIS OF OSTEOMYELITIS
* LOCAL ANTIBIOTIC TREATMENT OF INFECTION/OSTEOMYELITIS

Presented at Indiana Podiatric Medical Association Scientific Meeting. Indianapolis, IN. October, 1987.

127. * HOW TO UTILIZE ANTIBIOTIC-LOADED BONE CEMENT IN THE TREATMENT OF FOOT INFECTIONS
* EVALUATION AND MANAGEMENT OF POSTOPERATIVE INFECTIONS
* RADIOGRAPHIC, SCINTIGRAPHIC, COMPUTED TOMOGRAPHIC AND MAGNETIC RESONANCE IMAGED STUDIES IN EVALUATION OF THE NATURE AND EXTENT OF FOOT AND ANKLE INFECTION

Presented at American Podiatric Medical Association Region 1 National Scientific Meeting. Boston, MA. October, 1987.

128. * NON-STEROIDAL ANTI-INFLAMMATORY DRUGS
* MANAGEMENT AND EVALUATION OF POSTOPERATIVE COMPLICATIONS
* MRI AND CT SCANNING/ANTIBIOTIC-LOADED BONE CEMENT

Presented at Michigan Podiatric Medical Association Scientific Meeting. Kalamazoo, MI. October, 1987.

129. THE DIABETIC FOOT

Presented at Deaconess Hospital Department of Medical Education Meeting. St. Louis, MO. October, 1987.

130. * BIOMECHANICAL, RADIOGRAPHIC AND CLINICAL ASSESSMENT OF PEDAL OSTEOTOMIES
* ORIGIN AND MANAGEMENT OF THE PROBLEM OSTEOTOMY
* UTILIZATION OF ANTIBIOTIC-LOADED BONE CEMENT IN THE TREATMENT OF FOOT AND ANKLE INFECTION
* POSTOPERATIVE INFECTIONS
* SURGICAL ALTERNATIVES TO TRIPLE ARTHRODESIS
* OSSEOUS NEOPLASTIC DISEASE OF THE FOOT: RADIOGRAPHIC EVALUATION AND PRINCIPLES OF SURGICAL ONCOLOGY FOR COMMON LESIONS
* EVALUATION AND MANAGEMENT OF INFLAMMATORY ARTHRITIS OF THE FOOT
* METALLIC FIXATION IN THE FOOT AND PODIATRIC METALLURGY
* POLYMERS IN THE FOOT: HARMFUL OR HELPFUL?
* RADIOGRAPHIC EVALUATION OF THE DIABETIC FOOT
* CT, MRI AND TENOGRAPHY: CLINICOPATHOLOGIC CORRELATIONS

Presented at William Scholl College of Podiatric Medicine Alumni Association Lectures. San Juan, PUERTO RICO. January 18-23, 1988.

131. * OFFICE MANAGEMENT OF THE OSTEOARTHRITIC PATIENT
* ANTIBIOTIC-IMPREGNATED BONE CEMENT
* TOMOGRAPHY OF THE FOOT AND ANKLE

Presented at Florida Podiatric Medical Association Scientific Symposium. Orlando, FL. January 28-29, 1988.

132. THE DIABETIC FOOT

Presented at Lutheran Medical Center Department of Medical Education. St. Louis, MO. February, 1988.

133. * HEEL PAIN
* EVALUATION OF THE ARTHRITIC PATIENT
* SPORTS-RELATED FOOT INJURIES

Presented at New York State Podiatric Medical Association, Monroe Division. Rochester, NY. February 6, 1988.

134. UTILIZATION OF NSAID'S IN PODIATRIC MEDICINE AND SURGERY

Presented at Indianapolis Areas Podiatrists Meeting. Indianapolis, IN. February 25, 1988.

135. SURGICAL MANAGEMENT OF THE ARTHRITIC FOOT

Presented at Kansas State Podiatry Society Meeting, University of Kansas Medical Center. Wichita, KS. March 5, 1988.

136. THE OPERATIVE MANAGEMENT OF DIABETIC FOOT INFECTIONS
Presented at New Hampshire Podiatry Society Meeting. March 6, 1988.

137. * EARLY DIAGNOSIS AND TREATMENT OF INFECTION
* RADIOGRAPHIC EVALUATION OF AN INFECTIOUS PROCESS OF THE FOOT AND ANKLE
Presented for PICA (Podiatry Insurance Company of America). Houston, TX. March 18, 1988.

138. OPERATIVE AND NON-OPERATIVE MANAGEMENT OF OSTEOARTHRITIS
Presented at St. Petersburg Podiatry Society Meeting. St. Petersburg, FL. March 31, 1988.

139. EVALUATION AND MANAGEMENT OF THE DIABETIC FOOT
Presented at Deaconess Hospital Family Medicine Department Meeting. St. Louis, MO. April 7, 1988.

140. EVALUATION AND MANAGEMENT OF COMMON FOOT PROBLEMS
Presented at Florida Academy of Family Physicians Scientific Meeting. Jacksonville, FL. April 8, 1988.

141. * REVISIONAL SURGERY OF THE FOOT IN OSTEOARTHRITIS
* CT SCANNING OF THE FOOT AND ANKLE
Presented at Michigan Podiatric Medical Association Scientific Meeting. Battle Creek, MI. April 9, 1988.

142. EVALUATION AND MANAGEMENT OF COMMON FOOT PROBLEMS
Presented at Washington University School of Medicine, Department of Rheumatology. St. Louis, MO. April 13, 1988.

143. * BIOMECHANICS OF LESSER METATARSAL PATHOLOGY
* LESSER METATARSAL SURGERY
* CONGENITAL DEFORMITIES OF THE FOOT
* GENERAL PRINCIPLES OF REARFOOT SURGERY
* GENERAL PRINCIPLES OF RADIOGRAPHIC EVALUATION OF THE FOOT AND ANKLE
Presented at Midwest Board Review Course and Midwest Podiatry Conference Seminar. Chicago, IL. April 22-23, 1988.

144. SURGICAL MANAGEMENT OF OSTEOMYELITIS
Presented at Iowa College of Podiatric Medicine Annual Scientific Seminar. Des Moines, IA. April 30, 1988.

145. UTILIZATION OF NSAID'S IN PODIATRIC MEDICINE AND SURGERY
Presented at Minneapolis Podiatry Society Meeting. Minneapolis, MN. May 18, 1988.

146. PRINCIPLES IN THE MANAGEMENT OF THE ARTHRITIC FOOT
Presented at Duluth Podiatry Society Meeting. Duluth, MN. May 18, 1988.

147. UTILIZATION OF NSAID'S IN PODIATRIC MEDICINE AND SURGERY
Presented at Fort Wayne Podiatry Society Meeting. Fort Wayne, IN. May 26, 1988.

148. IMPLANT ARTHROPLASTY SURGERY: INDICATIONS AND UPDATE
Presented at Virginia Podiatry Society Meeting. Norfolk, VA. June 4, 1988.

149. EVALUATION AND MANAGEMENT OF POSTOPERATIVE INFECTIONS: THE LEGAL VIEWPOINT
Presented for PICA Risk Management Program Lectures. June 5, 1988.

150. * THE KELLER BUNIONECTOMY: A NEW LOOK AT AN OLD PROCEDURE
* EVALUATION AND MANAGEMENT OF INFECTION FOLLOWING IMPLANT ARTHROPLASTY OF THE FOOT
* OSTEOTOMY OF THE FIRST METATARSAL
Presented at William Scholl College of Podiatric Medicine Annual Scientific Meeting. Chicago, IL. June 10-12, 1988.

151. REHABILITATION OF THE SURGICAL PATIENT FOLLOWING FIRST METATARSAL SURGERY
Presented at Indiana Podiatric Medical Association Scientific Meeting. South Bend, IN. June 29, 1988.

152. EVALUATION AND MANAGEMENT OF COMMON SPORTS INJURIES OF THE FOOT AND ANKLE
Presented at Florida Academy of Osteopathic Family Medicine. Orlando, FL. August 5, 1988.

153. UTILIZATION OF A NEW THERAPEUTIC DEVICE FOR STRENGTHENING THE PLANTAR ARCH OF THE FOOT
Presented at American Podiatric Medical Association National Scientific Meeting. August 19, 1988.

154. * EVALUATION AND MANAGEMENT OF COMMON BENIGN TUMORS

OF THE FOOT AND ANKLE
* SURGICAL MANAGEMENT OF THE ARTHRITIC PATIENT
* EVALUATION AND MANAGEMENT OF PERIPHERAL NEUROPATHY

Presented at New York Podiatric Medical Society, American College of Foot Surgeons, Western New York Division Joint Scientific Meeting. Buffalo, NY. September 3, 1988.

155. UTILIZATION OF ANTIBIOTIC-LOADED BONE CEMENT IN THE MANAGEMENT OF OSTEOMYELITIS OF THE FOOT AND ANKLE

Presented at the Foot and Ankle Institute Annual Scientific Symposium. Philadelphia, PA. September 23, 1988.

156. EVALUATION AND MANAGEMENT OF COMMON ARTHRITIC SYNDROMES OF THE FOOT AND ANKLE

Presented at Michigan Podiatric Medical Association. Boyn Highland, MI. September 30, 1988.

157. * TENOGRAPHY OF THE FOOT AND ANKLE
* MAGNETIC RESONANCE IMAGING OF THE FOOT AND ANKLE
* SURGICAL MANAGEMENT OF FLATFOOT DEFORMITY
* REFLEX SYMPATHETIC DYSTROPHY SYNDROME: EVALUATION AND TREATMENT
* NON-STEROIDAL ANTI-INFLAMMATORY DRUGS

Presented at Western Pennsylvania Podiatry Society Scientific Meeting. Pittsburgh, PA. September 31 and October 1, 1988.

158. EVALUATION AND MANAGEMENT OF BENIGN SOFT TISSUE AND OSSEOUS NEOPLASMS OF THE FOOT AND ANKLE

Presented at Missouri Podiatric Medical Association Scientific Meeting. Kansas City, MO. October 7, 1988.

159. EVALUATION AND MANAGEMENT OF BENIGN BONE TUMORS OF THE FOOT AND ANKLE WITH PARTICULAR REFERENCE TO DIAGNOSTIC IMAGING

Presented at Keystone Podiatry Society Meeting. Harrisburg, PA. October 14-15, 1988.

160. EVALUATION AND MANAGEMENT OF THE DIABETIC FOOT

Presented at Deaconess Hospital Department of Medicine Meeting. St. Louis, MO. November 8, 1988.

161. EVALUATION AND MANAGEMENT OF COMMON DIABETIC FOOT PROBLEMS

Presented at University of Indiana Medical School Scientific

Meeting. South Bend, IN. November 9, 1988.

162. UTILIZATION OF ORAL MEDICATION IN THE MANAGEMENT OF OSTEOARTHRITIS IN THE OFFICE SETTING
Presented to Indiana Podiatric Medical Association Scientific Meeting. South Bend, IN. November 16, 1988.

163. * UTILIZATION OF TENOGRAPHY IN EVALUATION OF TENDON PROBLEMS OF THE FOOT AND ANKLE
* MAGNETIC RESONANCE IMAGING OF THE FOOT AND ANKLE
* PRINCIPLES IN THE MANAGEMENT OF COMMON BENIGN BONE TUMORS OF THE FOOT AND ANKLE
Presented to the Massachusetts Podiatry Society. Boston, MA. November 19, 1988.

164. * PRINCIPLES IN THE MANAGEMENT OF SOFT TISSUE AND BONE TUMORS OF THE FOOT AND ANKLE
* UTILIZATION OF ANTIBIOTIC-LOADED BONE CEMENT IN THE MANAGEMENT OF THE DIABETIC SOFT TISSUE AND BONE INFECTIONS
* CHARCOT'S JOINT DISEASE: NON-OPERATIVE AND OPERATIVE MANAGEMENT
Presented to Denver Podiatry Society. Denver, CO. February 3-4, 1989.

165. MANAGEMENT OF RHEUMATIC SYNDROMES OF THE FOOT AND ANKLE
Presented to Deaconess Hospital Department of Family Medicine. St. Louis, MO. February 14, 1989.

166. HALLUX LIMITUS: PRINCIPLES OF SURGICAL MANAGEMENT AND REHABILITATION FOLLOWING SURGERY
Presented to Central Massachusetts Podiatry Society. Worcester, MA. February 28, 1989.

167. EVALUATION AND MANAGEMENT OF TENDON PATHOLOGY OF THE FOOT AND ANKLE
Presented to Western Massachusetts Podiatry Society. March 1, 1989.

168. * EVALUATION AND MANAGEMENT OF NEUROPATHY ASSOCIATED BONE AND JOINT DISEASE OF THE DIABETIC FOOT
* RADIOGRAPHIC EVALUATION OF BENIGN AND MALIGNANT OSSEOUS NEOPLASM OF THE FOOT AND ANKLE
Presented at the St. Louis Podiatry Seminar. St. Louis, MO.

March 3, 1989.

169. * RADIOGRAPHIC EVALUATION OF POSTOPERATIVE INFECTIOUS DISEASE OF THE FOOT AND ANKLE
* PRINCIPLES IN THE MANAGEMENT OF BENIGN OSSEOUS AND SOFT TISSUE TUMORS

Presented to Texas Podiatry Society. Houston, TX. March 4, 1989.

170. * UTILIZATION OF RADIONUCLIDE BONE IMAGING IN THE EVALUATION OF PATHOLOGY IN THE DIABETIC FOOT
* CURRENT CONCEPTS OF NEUROPATHIC DISEASE IN THE DIABETIC FOOT

Presented at Diabetic Foot Symposium of the American College of Foot Orthopedics. Chicago, IL. March 30, 1989.

171. * PRINCIPLES OF FOREFOOT RECONSTRUCTION AND LESSER METATARSAL OSTEOTOMIES
* COMMON REARFOOT OPERATIVE PROCEDURES

Presented to Annual Surgical Board Review Conference Midwest Podiatry Meeting. Chicago, IL. March 31, 1989.

172. APPLICATION OF MAGNETIC RESONANCE IMAGING FOR THE EVALUATION OF TRAUMA OF THE FOOT AND ANKLE

Presented to the Midwest Podiatry Conference Annual Scientific Sessions. Chicago, IL. April 1, 1989.

173. EVALUATION AND MANAGEMENT OF HEEL-SPUR AND HEEL-SPUR-LIKE SYNDROMES

Presented to Western Pennsylvania Podiatry Society. Harrisburg, PA. March 28, 1989.

174. * MAGNETIC RESONANCE IMAGING FO THE FOOT AND ANKLE
* TENOGRAPHY IN THE EVALUATION OF FOOT AND ANKLE PAIN

Presented to the National Podiatric Medical Association Annual Scientific Meeting. Miami, FL. May 6, 1989.

175. * RADIOGRAPHIC EVALUATION OF BONE AND JOINT DISEASE IN THE DIABETIC FOOT
* UTILIZATION OF ANTIBIOTIC-LOADED BONE CEMENT IN THE TREATMENT OF BONE AND SOFT TISSUE INFECTIONS OF THE DIABETIC FOOT

Presented to Annual Scientific Meeting Veterans' Administration Podiatry Service. Minneapolis, MN. May 9, 1989.

176. PRINCIPLES OF THE UTILIZATION OF ANTIBIOTIC-LOADED BONE CEMENT IN THE MANAGEMENT OF COMMON SOFT TISSUE AND BONE INFECTIONS OF THE FOOT AND ANKLE

Presented to the Department of Surgery, Deaconess Hospital. St. Louis, MO. May 10, 1989.

177. ANTIBIOTIC SELECTION IN THE MANAGEMENT OF COMMON INFECTIONS IN THE DIABETIC FOOT

Presented to Florida Podiatry Society. Melbourne, FL. May 18, 1989.

178.
* PRINCIPLES IN THE MANAGEMENT OF POSTOPERATIVE PAIN
* PRINCIPLES IN THE MANAGEMENT OF BENIGN SOFT TISSUE AND BONE TUMORS OF THE FOOT AND ANKLE
* APPLICATION OF MAGNETIC RESONANCE IMAGING OF THE FOOT AND ANKLE
* TENOGRAPHY OF THE FOOT AND ANKLE

Presented to Virginia Podiatry Society. Virginia Beach, VA. June 2-3, 1989.

179.
* EVALUATION AND MANAGEMENT OF ISCHEMIC VASCULAR DISEASE IN THE DIABETIC FOOT
* EVALUATION AND MANAGEMENT OF NEUROPATHY IN THE DIABETIC PATIENT
* PRINCIPLES OF INCISION AND DRAINAGE IN THE MANAGEMENT OF DIABETIC FOOT INFECTIONS
* OVERVIEW OF PATHOLOGY UNIQUE TO THE DIABETIC FOOT
* ARTHROPLASTY FOR THE MANAGEMENT OF HALLUX LIMITUS
* UTILIZATION OF BONE GRAFTING IN THE MANAGEMENT OF HALLUX LIMITUS
* EVALUATION AND MANAGEMENT OF DELAYED UNION AND NON-UNION OF BONE WITH ELECTRICAL STIMULATIONS

Presented to annual Scientific Meeting, William Scholl College of Podiatric Medicine and Surgery. Chicago, IL. June 8-10, 1989.

180. EVALUATION AND MANAGEMENT OF BONE AND JOINT INFECTION IN THE DIABETIC FOOT

Presented to Jacksonville Podiatry Society. Jacksonville, FL. June 12, 1989.

181. A RETROSPECTIVE ANALYSIS OF THE SAFETY OF ELECTIVE FOOT SURGERY IN THE DIABETIC PATIENT

Presented to Annual Scientific Meeting, American Podiatric

Medical Association. Boston, MA. August 18, 1989.

182. THE EVALUATION AND MANAGEMENT OF PAIN IN THE POSTOPERATIVE PATIENT
Presented to Missouri State Podiatric Medical Society Annual Scientific Meeting. St. Louis, MO. September 7, 1989.

183. * EVALUATION AND MANAGEMENT OF PAIN IN THE POSTOPERATIVE PATIENT
* PRINCIPLES IN THE RADIOGRAPHIC EVALUATION OF COMMON BENIGN BONE TUMORS OF THE FOOT AND ANKLE
Presented to Wisconsin State Podiatry Society Annual Scientific Meeting. Madison, WI. September 15, 1989.

184. RADIOLOGY OF THE DIABETIC FOOT
Presented to Central Florida Podiatry Society. Orlando, FL. September 22, 1989.

185. * MANAGEMENT OF BENIGN BONE TUMORS OF THE FOOT AND ANKLE
* MANAGEMENT OF POSTOPERATIVE PAIN
* TENOGRAPHY OF THE FOOT AND ANKLE
* EVALUATION AND MANAGEMENT OF POSTOPERATIVE INFECTIONS
* SURGICAL MANAGEMENT OF SUBTALAR JOINT PAIN
Presented to Arkansas State Podiatry Annual Meeting. Russerville, AR. October 6-7, 1989.

186. * MRI OF THE FOOT AND ANKLE
* TENOGRAPHY OF THE FOOT AND ANKLE
* INFECTION MANAGEMENT IN THE DIABETIC FOOT
Presented to Indiana State Podiatry Society. Indianapolis, IN. October 21, 1989.

187. BONE AND JOINT DISEASE IN THE DIABETIC FOOT
Presented to St. Louis University Medical College Department of Geriatric Medicine. St. Louis, MO. October 25, 1989.

188. PEDIATRIC FOOT DEFORMITY: EVALUATION OF COMMON PROBLEMS
Presented to Deaconess Hospital Department of Family Medicine. St. Louis, MO. November 21, 1989.

189. BONE AND JOINT DISORDERS IN THE DIABETIC FOOT
Presented to the Annual Diabetes Symposium, Kilo Diabetes and Vascular Research Foundation. St. Louis, MO. December 2, 1989.

190. EVALUATION OF FOOT AND ANKLE INJURIES UTILIZING MRI
Presented to the Memphis Podiatry Society. Memphis, TN. January 24, 1990.

191. MANAGEMENT OF OSTEOMYELITIS UTILIZING ANTIBIOTIC BEADS
Presented to the Northwest Podiatric Medical Institute of Cozumel, MEXICO. February 3, 1990.

192. RHEUMATIC DISEASE: FOOT MANIFESTATIONS
Presented to the Department of Rheumatology, Washington University School of Medicine. St. Louis, MO. February 28, 1990.

193. POSTOPERATIVE REHABILITATION
Presented to the St. Louis Podiatry Meeting Society. St. Louis, MO. March 3, 1990.

194. REVISIONAL SURGERY IN FAILED DIABETIC AMPUTATION TREATMENT OF NON-UNIONS
Presented to Marlboro Hospital Podiatry Department. Marlboro, MA. March 10, 1990.

195. * EVALUATION AND MANAGEMENT OF OSSEOUS NEOPLASMS
* NON-SURGICAL AND SURGICAL MANAGEMENT OF SUBTALAR JOINT PAIN
* LESSER METATARSAL SURGERY
* SURGICAL MANAGEMENT OF FLEXIBLE FLATFOOT DEFORMITY
Presented to the Midwest Podiatry Meeting. Chicago, IL. April 6-8, 1990.

196. RHEUMATIC DISORDERS OF THE FOOT AND ANKLE
Presented to the Department of Family Medicine, Deaconess Hospital. St. Louis, MO. April 17, 1990.

197. SURGICAL MANAGEMENT OF FLEXIBLE FLATFOOT DEFORMITY
Presented to the Podiatry Department, Yale University. New Haven, CT. April 18, 1990.

198. * MANAGEMENT OF POSTOPERATIVE PAIN
* EVALUATION AND TREATMENT OF POSTOPERATIVE INFECTION
* EVALUATION AND MANAGEMENT OF SUBTALAR JOINT PAIN
Presented to Connecticut State Podiatry Society. Hartford, CT. April 19-21, 1990.

199. * MANAGEMENT OF POSTOPERATIVE PAIN

* SURGICAL MANAGEMENT OF SUBTALAR JOINT PAIN
Presented to the University of Massachusetts Medical College Podiatry Department. Worchester, MA. May 11, 1990.

200. BONE AND JOINT DISEASE IN THE DIABETIC FOOT
Presented to the American Podiatry Association Annual Scientific Meeting. Las Vegas, NV. August 10, 1990.

201. EVALUATION AND MANAGEMENT OF POSTOPERATIVE INFECTIONS
Presented to the Missouri State Podiatry Society Annual Scientific Meeting. Kansas city, KS. September 9, 1990.

202. * MANAGEMENT OF WEB SPACE INFECTIONS
* THE SCARF AND LUDLOFF OSTEOTOMY: INDICATIONS AND APPLICATIONS
* MANAGEMENT OF DELAYED UNION AND NON-UNION MODIFIED WATERMAN AND COTTON OSTEOTOMY
September 14-15, 1990.

203. EVALUATION OF COMMON ANKLE INJURIES
Presented to the Department of Family Medicine, Deaconess Hospital. St. Louis, MO. September 18, 1990.

204. * DIAGNOSTIC IMAGING FOR INFECTION: CONCEPTS AND CONTROVERSIES
* LOCAL ANTIBIOTIC THERAPY IN FOOT AND ANKLE INFECTIONS
* POSTOPERATIVE INFECTIONS
Presented to the Pittsburgh Podiatry Hospital. Pittsburgh, PA. October 5-6, 1990.

205. * MANAGEMENT OF RECURRENT NEUROMA PAIN
* SURGICAL MANAGEMENT OF PLANTAR FIBROMATOSIS
* OSTEOMYELITIS: CURRENT TRENDS IN MANAGEMENT
* TENDON AND LIGAMENT INJURIES IN THE ATHLETE
* CHARCOT JOINT DISEASE
Presented to the Region 1 Podiatry Meeting. Boston, MA. October 12-14, 1990.

206. * SURGICAL MANAGEMENT OF SUBTALAR JOINT PAIN POSTOPERATIVE INFECTIONS
* NON-UNIONS: DIAGNOSIS AND MANAGEMENT
Presented to the Pioneer Podiatry Society. Lake Texoma, OK. October 18-20, 1990.

207. * BLEEDING DISORDERS IN THE SURGICAL PATIENT
* MANAGEMENT OF LISFRANC FRACTURE DISLOCATIONS
* MANAGEMENT OF COMMON BONE TUMORS
* TREATMENT OF NON-UNIONS

Presented to the Northern Podiatry Podiatric Academy. Cleveland, OH. November 9-10, 1990.

208. * SURGICAL MANAGEMENT OF INFECTION
* POSTOPERATIVE INFECTIONS

Presented to the Ohio Podiatric Medical Association. Columbus, OH. November 16-17, 1990.

209. * METABOLIC NEUROPATHIES: DIAGNOSIS AND MANAGEMENT
* MANAGEMENT OF PAINFUL NEUROPATHIES: DRUG THERAPY
* EVALUATION OF ELECTRODIAGNOSTIC STUDIES

Presented to the Pennsylvania Podiatric Medical Association Annual Scientific Seminar. Hershey, PA.

210. * EVALUATION AND MANAGEMENT OF OSTEOMYELITIS
* TOE WEB INFECTIONS
* ANTIBIOTIC-LOADED BONE CEMENT
* POSTOPERATIVE INFECTIONS

Presented to William Scholl college of Podiatry. Chicago, IL. December 15, 1990.

211. * SURGICAL MANAGEMENT OF SUBTALAR JOINT PAIN
* POSTOPERATIVE INFECTIONS

Presented at Pittsburgh Podiatry Hospital. Pittsburgh, PA. February 2, 1991.

212. * RETROSPECTIVE ANALYSIS OF COMPLICATIONS FOLLOWING THE STA-PEG OPERATION
* ANTIBIOTIC-LOADED BONE CEMENT: A LOOK BACK
* INFECTION RATES WITH CONCURRENT NAIL AND BONE SURGERY

Presented at American College of Foot Surgeons. San Francisco, CA. February 14-16, 1991.

213. MANAGEMENT OF NON-UNIONS

Presented at Arkansas State Podiatry Society. Little Rock, AR. March 2, 1991.

214. * POSTOPERATIVE INFECTIONS
* SURGICAL MANAGEMENT OF PLANTAR FIBROMATOSIS
* NON-UNION OF BONE: TREATMENT

Presented at St. Louis Podiatry Seminar. St. Louis, MO. March 8-9, 1991.

215. * PAIN FOLLOWING NEUROMA SURGERY
* PLANTAR FIBROMATOSIS
* POSTOPERATIVE INFECTIONS
Presented at Washington State Podiatry Society. Semi Amu, WA. March 23, 1991.

216. * OSTEOMYELITIS IN THE DIABETIC FOOT
* RADIOGRAPHIC EVALUATION OF THE DIABETIC FOOT
* NEUROPATHY IN DIABETES
Presented at Wichita, KS. April 5-6, 1991.

217. * ADVANCES IN THE MANAGEMENT OF THE DIABETIC FOOT
* SUBTALAR JOINT PAIN
Presented at Midwest Podiatry Conference. Chicago, IL. April 11-13, 1991.

218. * POSTOPERATIVE INFECTION
* SUBTALAR JOINT PAIN
* MANAGEMENT OF COMMON BONE TUMORS
Presented at Kentucky State Podiatry Society. Frankfort, KY. April 20, 1991.

219. * NON-UNION OF BONE
* POSTOPERATIVE INFECTION
* RECURRENT NEUROMA PAIN
Presented at Coney Island Hospital. New York, NY. April 27, 1991.

220. * PLANTAR FIBROMATOSIS
* SUBTALAR JOINT PAIN
* POSTOPERATIVE INFECTION
Presented at Region 3 Podiatry Conference. Atlantic City, NJ. May 2-4, 1991.

221. SUBTALAR JOINT PAIN
Presented at Veterans' Administration Hospital. Minneapolis, MN. May 4, 1991.

222. * RECURRENT NEUROMA PAIN
* PLANTAR FIBROMATOSIS
* NON-UNION OF BONE

* SUBTALAR JOINT PAIN

Presented at Virginia Podiatry Society. Virginia Beach, VA. July 6, 1991.

223. * EVALUATION AND MANAGEMENT OF NEUROPATHIES
* NON-UNION: EVALUATION AND MANAGEMENT

Presented at Connecticut State Podiatry Society. July 19-21, 1991.

224. POSTOPERATIVE OSTEOMYELITIS

Presented at APMA National Scientific Meeting. Orlando, FL. August 9, 1991.

225. * SOFT TISSUE TUMORS OF THE FOOT
* PERIPHERAL NEUROPATHIES
* NON-UNION: ELECTRICAL MANAGEMENT
* SUBTALAR JOINT PAIN

Presented at Oregon State Podiatry Society. Bend, OR. August 24, 1991.

226. * SURGICAL MANAGEMENT OF POSTOPERATIVE INFECTIONS
* EVALUATION AND MANAGEMENT OF NSAID-INDUCED COMPLICATIONS
* EVALUATION AND MANAGEMENT OF DEGENERATIVE ARTHRITIS

Presented at Marlboro Hospital. Marlboro, MA. September 28, 1991.

227. * COMPLICATIONS OF BUNION SURGERY
* NON-UNION OF DISTAL OSTEOTOMY IN THE MANAGEMENT OF HALLUX VALGUS
* A REVIEW OF THE KELLER BUNIONECTOMY
* CLINICAL AND RADIOGRAPHIC EVALUATION OF FLATFOOT DEFORMITY
* SUBTALAR JOINT ARTHRITIS
* RADIOGRAPHIC EVALUATION OF ARTHRITIS

Presented at Region 1 Scientific Seminar. Boston, MA. October 10-12, 1991.

228. * EVALUATION AND MANAGEMENT OF POSTOPERATIVE INFECTIONS
* CURRENT AND FUTURE BIOMATERIAL CONSIDERATIONS IN IMPLANT SURGERY
* UPDATE ON NON-STEROIDAL ANTI-INFLAMMATORY MEDICATIONS
* MANAGEMENT OF NON-UNION FOLLOWING OSTEOTOMY OR FRACTURE

Presented at Pennsylvania Podiatric Medical Association. Hershey, PA. November 7-10, 1991.

229. * EVALUATION AND MANAGEMENT OF ABNORMAL BONE HEALING
* IMPLANTS AND BIOMATERIALS
* DISTAL METAPHYSICAL OSTEOTOMY

Presented at Pennsylvania Podiatric Medical Association. "Hershey West". Palm Springs, CA. December 5-7, 1991.

230. EVALUATION OF THE DIABETIC FOOT

Presented at the Annual Symposium of the Kilo Diabetes and Vascular Research Foundation. St. Louis, MO. December 14, 1991.

231. * SURGICAL MANAGEMENT OF FLATFOOT DEFORMITY
* HEEL PAIN AND RHEUMATIC PATHOLOGIES
* POSTOPERATIVE INFECTIONS
* NON-STEROIDAL ANTI-INFLAMMATORY MEDICATIONS

Presented at Pittsburgh Podiatry Hospital. Pittsburgh, PA. February 2, 1992.

232. REQUIREMENTS FOR AN ENTRY LEVEL RESIDENCY PROGRAM IN PODIATRY

New Orleans, LA. March 6, 1992.

233. * RADIOLOGY OF OSTEOMYELITIS
* IMPLANT MODIFIED INFECTIONS

Presented at Florida Podiatry Association. Singer Island, FL. March 7, 1992.

234. * IMPLANTS AND BIOMATERIALS
* COMPLICATIONS OF IMPLANT ARTHROPLASTY

Presented at St. Louis Podiatry Seminar. St. Louis, MO. March 20-21, 1992.

235. * MID-SHAFT OSTEOTOMY FOR BUNION CORRECTION
* DIGITAL SURGERY
* IMPLANT COMPLICATIONS

Presented at Pennsylvania Podiatry Association Board Review Course. Harrisburg, PA. April 2-3, 1992.

236. * PAIN FOLLOWING NEUROMA SURGERY
* EVALUATION AND MANAGEMENT OF PERIPHERAL NEUROPATHY
* HEEL PAIN: EVALUATION AND TREATMENT

Presented at Northern Ohio Podiatry Academy. Youngstown, OH. April 4, 1992.

237. RADIOGRAPHIC EVALUATION OF ANKLE INJURIES
Presented at ACFS/ACFO Annual Scientific Conference. Chicago, IL. April 9, 1992.

238. EVALUATION AND MANAGEMENT OF NON-UNION POSTOPERATIVE INFECTIONS
Presented at Midwest Podiatry Conference. Chicago, IL. April 10-11, 1992.

239. * COMPLICATIONS OF FOOT SURGERY: EVALUATION AND TREATMENT
* EVALUATION AND MANAGEMENT OF BONE TUMORS
Presented at Midwest Podiatry Board Review Course. Chicago, IL. April 10-11, 1992.

240. COMMON RHEUMATIC DISORDERS AFFECTING THE FOOT
Presented for the Rheumatology Department, Washington University School of Medicine. St. Louis, MO. June 3, 1992.

241. THE DIABETIC FOOT
Presented at Annual Summer Geriatric Institute, St. Louis University Medical School. St. Louis, MO. June 17, 1992.

242. * DIABETES MELLITUS IN THE ELDERLY
* TENDON PATHOLOGY: EVALUATION AND TREATMENT
* DISTAL METAPHYSICAL OSTEOTOMY IN BUNION SURGERY
* MRI OF THE FOOT AND ANKLE
Presented at Connecticut State Podiatry Society. Mystic, CT. July 17-19, 1992.

243. * SYNOVECTOMY OF THE FOOT AND ANKLE
* AUTONOMIC NEUROPATHY IN THE DIABETIC FOOT
Presented at Kansas City Podiatry Residency. Kansas City, MO. August 15, 1992.

244.
Presented at Missouri State Podiatry Society Annual Scientific Meeting. Kansas City, MO. September 11, 1992.

245. * PAIN FOLLOWING NEUROMA SURGERY
* SUBTALAR JOINT PAIN
* POSTOPERATIVE INFECTIONS
* EVALUATION AND MANAGEMENT OF NON-UNION

* PRINCIPLES OF FLATFOOT SURGERY
* NEW IMPLANTS AND BIOMATERIALS
Presented at Texas Podiatry Association. Dallas, TX. September 19-20, 1992.

246. * SELECTION AND UTILIZATION OF TOPICAL STEROIDS
* TREATMENT OF CUTANEOUS MYCOSES
* WEB SPACE INFECTIONS
* REFLEX SYMPATHETIC DYSTROPHY SYNDROME
* REARFOOT SURGERY FOR PES CAVUS
* TREATMENT OF PUNCTURES AND LACERATIONS
* EVALUATION AND MANAGEMENT OF VASOSPASTIC DISORDERS
Presented at Region 1Annual Scientific Meeting. Boston, MA. October 9-11, 1992.

247. * DIABETES MELLITUS IN THE ELDERLY
* SURGICAL MANAGEMENT OF OSTEOMYELITIS
* DIABETIC NEUROPATHY
* SURGICAL MANAGEMENT OF POSTOPERATIVE INFECTIONS
Presented at Arkansas Podiatry Association. Hot Springs, AR. October 24-25, 1992.

248. * RISK ASSESSMENT FOR THE PODIATRIC SURGICAL PATIENT
* POSTOPERATIVE MANAGEMENT OF THE PODIATRY SURGICAL PATIENT
* DECISION MAKING IN HALLUX VALGUS SURGERY
* CLINICAL PHARMACOLOGY
Presented at Pennsylvania Podiatry Association Annual Scientific Meeting. Hershey, PA. November 5-8, 1992.

249. * DIABETIC NEUROPATHY
* OSTEOMYELITIS: CLINICAL MANAGEMENT
* PAIN FOLLOWING NEUROMA SURGERY
* EVALUATION AND TREATMENT OF NON-UNION
Presented at Colorado State Podiatry Association. Denver, CO. December 5-6, 1992.

250. THE AGING FOOT IN THE NURSING HOME
Presented at The Symposium on Long Term Care, St. Louis University Medical School. St. Louis, MO. December 12, 1992.

251. * PREOPERATIVE EVALUATION OF THE DIABETIC PATIENT
* TREATMENT OF THE CHARCOT FOOT
* FOOT PATHOLOGY IN THE UNDIAGNOSED DIABETIC PATIENT

* HALLUX LIMITUS

Presented at North Carolina State Podiatry Seminar. Fayetteville, NC. January 21-23, 1993.

252. * PAIN AND PAIN MANAGEMENT
* COMPLICATIONS OF NEUROMA SURGERY
* COMPLICATIONS OF FOOT SURGERY

Presented at Midwest Annual Scientific Conference. Chicago, IL. March 5-7, 1993.

253. * OPIOID RECEPTORS AND PAIN MANAGEMENT
* PERIPHERAL NEUROPATHY

Presented at Super Seminar. Las Vegas, NV. March 13-14, 1993.

254. * DIABETES MELLITUS IN THE ELDERLY
* SURGICAL MANAGEMENT OF PLANTAR FIBROMA
* TREATMENT OF NON-UNION
* POSTOPERATIVE INFECTION

Presented at Eastern Ohio Academy. Youngstown, OH. March 21, 1993.

255. * POSTOPERATIVE PAIN MANAGEMENT
* DIABETES IN THE ELDERLY PATIENT
* ORAL ANTIBIOTIC THERAPY IN PODIATRY
* COMPLICATIONS IN FOOT SURGERY

Presented at New York City Podiatry Association. New York, NY. March 27, 1993.

256. * NSAID THERAPY IN THE ELDERLY
* DIABETES IN THE ELDERLY
* MANAGEMENT OF NON-UNIONS
* POSTOPERATIVE PAIN

Presented at Pittsburgh Podiatry Hospital. Pittsburgh, PA. April 10, 1993.

257. * DIGITAL SURGERY
* MID-SHAFT OSTEOTOMY FOR BUNION DEFORMITY
* EVALUATION AND MANAGEMENT OF BUNION SURGERY COMPLICATIONS
* EVALUATION AND MANAGEMENT OF HEEL PAIN

Presented at Pennsylvania Podiatry Society APBS Board Review Course. Harrisburg, PA. April 15-18, 1993.

258. EVALUATION AND MANAGEMENT OF THE DIABETIC FOOT
Presented at the Department of Family Medicine, Deaconess Hospital. St. Louis, MO. April 20, 1993.

259. * DIABETES IN THE OLDER PATIENT
* EVALUATION AND MANAGEMENT OF POSTOPERATIVE INFECTIONS
* CURRENT TRENDS IN THE MANAGEMENT OF NON-UNION
Presented at Oklahoma Podiatry Society. Shangri-La, OK. May 1-2, 1993.

260. ELECTRICAL STIMULATION AND BONE GRAFTING FOR NON-UNION
Presented at Ohio Podiatry Society. Columbus, OH. May 15, 1993.

261. * DIABETIC ULCERATION IN THE OLDER PATIENT
* MANAGEMENT OF ARTHRITIS IN THE OLDER PATIENT
* EVALUATION AND MANAGEMENT OF NON-UNION
Presented at Foot and Ankle Symposium. Minneapolis, MN. May 22-23, 1993.

262. * DIABETIC NEUROPATHY: EVALUATION AND TREATMENT
* STEROID RESPONSIVE DISORDERS OF THE SKIN
* DIABETES IN THE ELDERLY PATIENT
* COMPLICATIONS OF FOOT SURGERY
Presented at Virginia Podiatry Society. Virginia Beach, VA. June 20, 1993.

263. COMPLICATIONS OF IMPLANT ARTHROPLASTY OF THE GREAT TOE
Presented at Missouri State Podiatry Society. St. Louis, MO. September 10, 1993.

264. * RADIOGRAPHIC EVALUATION FO ANKLE INJURIES
* RADIOGRAPHIC EVALUATION OF THE DIABETIC FOOT
* RADIOGRAPHIC EVALUATION OF BONE TUMORS
Presented at Texas Podiatry Society. Dallas, TX. September 11-12, 1993.

265. * CURRENT CONCEPTS IN DIABETIC NEUROPATHY
* DIABETES IN THE OLDER PATIENT
Presented at Northcoast Seminar. Cleveland, OH. October 21, 1993.

266. * OSTEOTOMY OF THE HALLUX FOR BUNION CORRECTION
* ARTHRODESIS IN THE MANAGEMENT OF BUNION DEFORMITY

* INFECTION MANAGEMENT FOLLOWING BUNION SURGERY
* VASOSPASTIC COMPLICATIONS OF SURGERY
* COMMON DERMATOSES AND TOPICAL STEROIDS
* REFLEX DYSTROPHY AND CAUSALGIA
* MANAGEMENT OF LACERATIONS AND PUNCTURE WOUNDS

Presented at Region 1 Podiatry Seminar. Boston, MA. October 23-24, 1993.

267. * USE OF NSAID'S IN THE OLDER PATIENT
* DVT AND PULMONARY EMBOLISM
* SYSTEMIC LUPUS: FOOT MANIFESTATIONS

Presented at Pennsylvania Podiatry Society. Hershey, PA. November 12-14, 1993.

268. * EVALUATION AND MANAGEMENT OF POSTOPERATIVE INFECTIONS
* USE AND ABUSE OF ANTI-INFLAMMATORY MEDICATIONS
* DVT AND PULMONARY EMBOLISM
* COMPLICATIONS OF BUNION SURGERY

Presented at North Carolina Podiatry Society. Greensboro, NC. January 13-15, 1993.

269. * MANAGEMENT OF DIABETIC ULCERS
* DIABETES IN THE OLDER PATIENT
* COMPLICATIONS OF DIABETIC NEUROPATHY
* MANAGEMENT OF OSTEOMYELITIS IN THE DIABETIC PATIENT

Presented at Houston Residency Program. Houston, TX. January 29, 1994.

270. THE AGING FOOT

Presented at Board Review Course, St. Louis University School of Medicine. St. Louis, MO. March 12, 1994.

271. * COMPLICATIONS OF BUNION SURGERY
* EVALUATION AND MANAGEMENT OF BUNION SURGERY
* SURGICAL MANAGEMENT OF PLANTAR FIBROMATOSIS
* EVALUATION AND MANAGEMENT OF POSTOPERATIVE PAIN
* EVALUATION AND SURGICAL MANAGEMENT OF OSTEOMYELITIS

Presented at Northeastern Academy of Podiatry. Youngstown, OH. March 20, 1994.

272. IMPLANTS AND BIOMATERIALS: CURRENT CONCEPTS
Presented at No Nonsense Seminar. Cleveland, OH. April 8, 1004.

273. * MANAGEMENT OF FLATFOOT DEFORMITY

* MRI OF THE FOOT AND ANKLE
Presented at Midwest Podiatry Conference. Chicago, IL. April 14-16, 1994.

274. * EVALUATION AND MANAGEMENT OF OSTEOMYELITIS
* COMPLICATIONS OF BUNION SURGERY
* ARTHRODESIS IN BUNION SURGERY
Presented for AACPPM. Livonia, MI. May 14, 1994.

275. * CURRENT CONCEPTS OF BONE HEALING
* SURGICAL MANAGEMENT OF FLATFOOT DEFORMITY
Presented at Pittsburgh Podiatry Hospital. Pittsburgh, PA. May 21-22, 1994.

276. * EVALUATION AND MANAGEMENT OF NON-UNION
* DVT AND PULMONARY EMBOLISM
* ANTIBIOTIC-LOADED BONE CEMENT AND OSTEOMYELITIS
Presented at Iowa State Podiatry Society. Des Moines, IA. June 11, 1994.

277. EVALUATION AND MANAGEMENT OF GERIATRIC FOOT DISORDERS
Presented at St. Louis University. St. Louis, MO. June 16, 1994.

278. * COMPLICATIONS OF BUNION SURGERY
* MANAGEMENT OF POSTOPERATIVE PAIN
* CONNECTIVE TISSUE DISORDERS
* ORAL ANTIFUNGAL THERAPY
Presented at Connecticut State Podiatry Society. Stanford, CT. July 15-17, 1994.

279. * EVALUATION AND MANAGEMENT OF RSDS
* CORONARY, RENAL AND CEREBRAL VASCULAR DISEASE IN THE PODIATRY PATIENT
* CURRENT CONCEPTS IN BONE HEALING
* THE SCARF AND LUDLOFF BUNIONECTOMY
Presented at Region 1 Podiatry Meeting. Boston, MA. August 25-27, 1994.

280. CURRENT CONCEPTS IN DIABETIC NEUROPATHY
Presented at Missouri State Podiatry Seminar. Kansas City, MO. September 9, 1994.

281. * DIAGNOSTIC IMAGING FOR INFECTIOUS DISEASE
* DIAGNOSTIC IMAGING FOR TENDON DISORDERS

* DIAGNOSTIC IMAGING FOR BONE TUMORS
* DIAGNOSTIC IMAGING FOR RHEUMATIC DISORDERS
Presented at Indiana State Podiatry Society. Indianapolis, IN. October 15, 1994.

282. * DIABETES MELLITUS IN THE OLDER PATIENT
* AUTONOMIC NEUROPATHY IN DIABETIC ULCERATION
* MANAGEMENT OF THE CHARCOT FOOT
* MANAGEMENT OF OSTEOMYELITIS IN THE DIABETIC FOOT
Presented at Flushing Hospital. Queens, NY. October 22, 1994.

283. * EVALUATION AND MANAGEMENT OF ANKLE LIGAMENT INJURY
* CURRENT CONCEPTS IN BONE HEALING
* PRINCIPLES IN DIGITAL SURGERY
* EVALUATION AND MANAGEMENT OF RHEUMATIC DISORDERS
Presented at Pennsylvania Podiatry Association. Hershey, PA. November 3-5, 1994.

284. DIABETIC NEUROPATHIES
Presented at Mount Sinai Hospital. Cleveland, OH. January 23, 1995.

Updates as of 12/31/2009

Recent seminars; scientific papers presented

American College foot and ankle surgeons
Annual scientific seminar
Los Angeles California
February 16-20, 1999

Deep venous thrombosis; diagnosis and treatment overview

Perioperative antibiotics; when and where

Reflex sympathetic dystrophy syndrome

Evaluation and management of osteomyelitis

Surgical management of plantar ulcers

Antibiotic loaded bone cement for osteomyelitis

New York state podiatric medical Association
Annual scientific seminar
New York City New York
January 20-23, 2005

Forefoot surgery in the older patient

Ulcer management in the older patient

Postoperative pain management in the geriatric patient

Delayed union and nonunion; strategies for evaluation and management

Nerve injury following bunion repair-anatomical considerations

Considerations in the prevention and treatment of complications following bunion surgery

Complex regional pain syndrome

Diabetes mellitus in the older patients

Connecticut podiatric medical Association
Annual scientific sessions
Uncasville, Connecticut
April 1-2, 2005

Indications and surgical technique for arthroereisis implant foot surgery

Calcaneal osteotomy techniques and fixation alternatives

The Cox 2 medications; are they safe ??

No nonsense seminar
Independence Ohio
March 14, 15 2008

Perioperative considerations in bunion surgery

Evaluation and management of neuropathy he treat patient

59th annual region 3 APMA scientific meeting
Atlantic City, New Jersey
April 22-25, 2008

Evaluation and management of motor neuropathy in the diabetic patient

Surgical management of ulceration in the diabetic patient

Evaluation and management of nonpainful neuropathy

Ohio College of podiatric medicine
Third annual "Southern exposure seminar
Cincinnati Ohio
May 1-4, 2008

Peds of the bone: A look at malpractice cases

The use and abuse of corticosteroids in podiatry

The foot and ESRD

Amputations and amputation techniques

The role of osteotomy configuration in bunion surgery

Western division of New York State podiatric medical Association
"Shuffle off to Buffalo" annual scientific meeting
September 19, 20, 2008
Buffalo New York

Bone and joint pathology in the diabetic patient

Motor neuropathy in a diabetic patient

American professional Wound Care Association
Annual scientific seminar
Fort Worth Texas
March 6, 7 2008

Assessment, diagnosis and management of wound infection

Management of painful neuropathy

North Central Academy of podiatric medicine
(No nonsense seminar"
Independence Ohio
March 14-16, 2008

Bone and joint pathology in a diabetic patient

Plantar fasciotomy: Are we seen a paradigm shift?

St. Louis podiatry seminar
St. Louis Missouri
March 20-21 2008

MRSA infection update

Elective foot surgery in a diabetic patient

Charcot's joint disease; evidence based medicine

Medial column stabilization for the correction of flatfoot deformity

Epidermal nerve fiber density testing in diabetic neuropathy

Evaluation and management of small fiber neuropathy

Ohio College of podiatric medicine
Scientific seminar
Independence Ohio
May 2, 3 2008

Evaluation and management of ulceration of the heel

Hyperbaric oxygen in the management of diabetic ulceration

Society of Puerto Rican podiatrists
Annual scientific meeting
Fajardo, Puerto Rico
June 19-21 2008

Motor neuropathy in the patient with diabetes

Evaluation and management of sensory neuropathy in the diabetic patient

Evaluation and management of infection and diabetic patient

Evaluation and management of ulceration in the diabetic patient

Virginia podiatric medical Association
Annual scientific sessions

Virginia Beach Virginia
June 26-28, 2008

Diabetic foot update 2008

Evaluation and management of fibromyalgia in the podiatry patient

Evaluation and management of symptomatic diabetic neuropathy

Oregon state podiatry Society
Annual scientific meeting
Portland Oregon
October 4, 2008

Small fiber neuropathy; evaluation and management

Oklahoma State podiatry Society
Annual scientific meeting
Tulsa Oklahoma
October 24, 2008

Evaluation and management of neuropathy in the diabetic patient

Evaluation and management of infection in the diabetic patient

William Goldfarb Foundation
Pennsylvania podiatric medical Association
"Podiatric approach on care of the elderly patient"
Annapolis Maryland
December 5-7, 2008

Evaluation and management of motor neuropathy

The role of homocysteine in diabetic foot pathology

New cardiovascular horizons
New Orleans Louisiana
September 12-14, 2008

Evaluation and management of diabetic neuropathy

Homocysteine and diabetic foot pathology

Evaluation and management of ulceration in the diabetic foot

St. Louis podiatry seminar
21st annual scientific session
Chesterfield Missouri
February 20, 21 2009

Operative factors and medical mistakes

Ethical issues in podiatric medicine and surgery

Nerve fiber regrowth in the diabetic patient

Decompression surgery in diabetic neuropathy

Improving results of flatfoot surgery

Pathophysiology of Charcot's joint disease

Surgical management of Charcot's joint disease

No nonsense seminar
North Central Academy of podiatric medicine
Cleveland Ohio
March 14, 2009

Evaluation of small fiber neuropathy

Diabetic Charcot joint disease; decision-making and treatment protocols

Diabetic foot global conference
Hollywood California
Friday, March 20, 2009

Pharmacologic management of diabetic peripheral neuropathy

The American College of Foot and Ankle Surgeons
Annual scientific conference, March 5-8, 2009

Perioperative management of the surgical patient:
Anti-inflammatories/disease modifying agents

Management of acute and chronic ankle joint injury

Ethical issues in surgical decision-making

Neuropathy-decompression versus surgical alternatives

Annual scientific conference;
Virginia nurse practitioner association
Williamsburg Virginia
March 19, 2009

Evaluation and management of diabetic peripheral neuropathy

Connecticut podiatric medical Association
Annual scientific conference
Uncasville, Connecticut

March 27, 28 2009

Getting on your last nerve: Evaluation and management of Morton's neuroma

Fibromyalgia; manifestations in the podiatry patient

Wrong site, wrong side, wrong surgery; examination of wrong site surgery

American Professional Wound Care Association
Annual scientific conference
Philadelphia Pennsylvania
April 3, 4 2009

Nutritional assessment of chronic wounds; key markers and values

Drug interactions and wound repair

Western Pennsylvania Hospital
Department of foot and ankle surgery
2009 Symposium on foot and ankle surgery
Pittsburgh Pennsylvania,
April 17, 18 2009

Effective surgical management of flatfoot deformity

Evaluation and management of Morton's neuroma

Diabetic foot update; 2009

Evaluation and management of Charcot's joint disease

Motor neuropathy in the diabetic patient

Medical mistakes; ethical considerations

Ninth cocci, homocysteine, and diabetic foot pathology

Fourth annual southern exposure scientific meeting
Cincinnati Ohio
April 23-26, 2009

Elective surgery in the patient with diabetes

Topical antibiotics, antiseptics, and bioburden

May I inject something here? A look at steroid injections

Ethical and ethical issues in podiatric surgery

Fibromyalgia: Podiatric manifestations and management

Improving the results of flatfoot surgery

Principles for reconstruction of cavus foot deformity

Oklahoma Podiatric Medical Association
Tulsa Oklahoma
May 14, 15 2009

Current standards for evaluation and management of plantar fasciitis

Ethics and podiatry

Nitroglycerin cocci, homocysteine, and diabetic foot pathology

APMA region 4 CME seminar
Ohio podiatric medical Association
June 4-6, 2009
Columbus Ohio

Diabetic neuropathy; surgical management versus medical care

Nitric oide, neuropathy, and wound healing in the diabetic patient

Virginia podiatric medical Association
Annual scientific meeting
Virginia Beach Virginia
June 25-28, 2009

Nerve fiber regeneration in the diabetic patient

The HAT graft for bunion correction

Epidermal nerve fiber density testing in a patient with diabetes

Evaluation of nitrate now practice cases, what or risk factors

American College of foot and ankle surgery
Diabetic foot update seminar
Santa Rosa California
July 9-11 2009

Evaluation and management of ankle fractures in the diabetic patient

DVT and pulmonary embolism; perioperative considerations

Evaluation and management of osteomyelitis in a diabetic patient

Texas A&M medical school
Fifth annual diabetes conference
Corpus Christi Texas
July 31-August 2, 2009

Evaluation and management of small fiber neuropathy

Oregon state podiatric Society
August 6, 2009

Evaluation and management of diabetic neuropathy

Hahnemann Medical College
Department of Neurology
Grand Rounds
September 4, 2009

Small fiber neuropathy

Tennessee State Podiatric Medical Association
Annual Scientific Conference
September 11, 2009

Surgical Management of Flatfoot Deformity
Management of Second Metatarsal Pathology
Evaluation and Management of Diabetic Neuropathy

Kansas City podiatric residency association
September 15, 2009
Osteotomy stabilization principles; compression without screws
Medical legal issues; documentation for common podiatric surgical procedures

Grand rounds
Alton Memorial Hospital
September 16, 2009

Principles to advance wound healing in chronic nonhealing wound management

Diabetic limb salvage conference
Georgetown University Hospital
September 24-26, 2009

Medical legal considerations in the management of osteomyelitis

Evaluation and management of small fiber neuropathy

Kilo diabetes and vascular research Foundation
Current topics and diabetes, endocrinology, and vascular disease
St. Louis Missouri November 20, 21 2009

Amputation prevention: Risk factors in the diabetic foot

Diagnosis and management of tarsal coalition and rigid flatfoot deformity

Temple University school of medicine
"A day with Allen Jacobs"
Philadelphia Pennsylvania
January 21, 2006

Bone and joint disorders in the diabetic patient

Office evaluation and treatment of diabetic neuropathy

Evaluation and management of Charcot's joint disease

Evaluation and management of infection in the diabetic patient

Chronic wound care for ulcerations in the diabetic patient

Prophylactic surgical management of forefoot ulceration

Evaluation and management of midfoot ulcers

Evaluation and management of heel ulceration

Documentation and medical legal issues

Missouri state podiatric medical Association
Annual scientific meeting
Kansas City Missouri
September 14, 15; 2006

Deep vein thrombophlebitis, prophylaxis, diagnosis and treatment

The role of bioburden in wound healing

Medical-legal considerations in foot and ankle surgery

Forest Park Hospital
Department of internal medicine; grand rounds
St. Louis Missouri
September 24, 2006

Neuropathic complications of the diabetic foot

Cardiovascular institute of the South
Annual scientific meeting
New Orleans Louisiana
November 2,-November 4, 2006

Pharmacologic approach for diabetic peripheral neuropathy

Goldfarb Foundation
35th annual clinical conference
Diabetes and PVD
Philadelphia Pennsylvania
November 10-12, 2006

Pharmacologic approach to neuropathic pain

APMA region one annual scientific conference
Boston Massachusetts
November 17, 2006

Evaluation and management of diabetic neuropathy

North central Academy of podiatric medicine
"No nonsense seminar"
Independence Ohio
March 9-11, 2007

Prevention, diagnosis, and management of DVT and pulmonary embolism

Lessons learned from malpractice cases reviewed

Connecticut podiatric medical Association
Annual scientific meeting
Uncasville, Connecticut
March 30-31, 2007

Bed to the bone: A look at podiatric malpractice cases

Operative factors in bunion surgery failure

MRSA: Update 2007

Pharmacologic management of diabetic neuropathy

Northeast New York podiatric medical Association
Annual scientific seminar
Albany New York (turning stone resort)
April 4-April 6, 2007

Management of flatfoot deformity; surgical principles

Ethics in podiatric medicine and surgery

Evaluation and management of diabetic ulceration and infection

Evaluation and management of posterior calcaneal pain

Evaluation and management of Achilles tendinosis

Annual scientific meeting
Orlando Florida
March 14-18, 2007

Diabetic neuropathy

DVT and pulmonary embolism

Perioperative management of the patient with rheumatoid arthritis

Etiologic considerations in neuromuscular foot deformity

St. Louis University school of medicine
Updated diabetes and endocrinology
St. Louis Missouri
March 23, 24 2007

Amputation prevention in the diabetic patient; risk factor identification

Connecticut podiatric medical Association
Annual scientific symposium
Uncasville, Connecticut
March 30-31, 2007

Bone and joint disorders in a diabetic patient

Wrong site, wrong foot, wrong procedure

Improving the results of flexible flat foot deformity

Evaluation and management of infection in this patient with diabetes

Northeast New York podiatric Academy
Annual scientific session
Albany New York
April 4-April 6, 2007

Evaluation and management of ulceration in diabetic patient

Evaluation and management of small fiber neuropathy

Principles for the management of flatfoot deformity

Improving the results of bunion surgery correction

Evaluation and management of posterior calcaneal pain

American professional Wound Care Association

Use and abuse of corticosteroids in foot and ankle pathology

American professional Wound Care Association
National clinical conference
Philadelphia Pennsylvania
April 6-8, 2007

Diabetic foot; infection versus bio burden

Selection in utilization of topical antimicrobial therapy in wound care

North Carolina foot and ankle Society
Annual scientific seminar and exposition
Greensboro North Carolina
January 25-28, 2007

Calcaneal osteotomy for flatfoot correction revisited

"Bed to the bone" a look at podiatry malpractice cases

Medical management of symptomatic diabetic neuropathy

Michigan state podiatric medical Association
"Great lakes conference"
Troy Michigan
February 17, 2007

Etiology and management of symptomatic diabetic neuropathy

19th annual St. Louis podiatry seminar
St. Louis Missouri
March 2-3, 2007

Evaluation and management of peripheral edema

Evaluation and management of chronic venous insufficiency, dermatitis, and ulceration

DVT and pulmonary embolism

Pharmacologic management of symptomatic neuropathy

MRSA: Management in a diabetic patient

The procedure of Paul Lapidus: A perspective on clinical application

Improving the results of calcaneal osteotomy

Injection of the Achilles tendon?

American College of foot and ankle surgeons

Annual scientific meeting
Philadelphia Pennsylvania
April 19-22, 2007

Hyperbaric oxygen and management of ulceration

Evaluation and management of diabetic foot infection

Evaluation and management of painful diabetic neuropathy

Virginia podiatric medical Association
Annual scientific meeting
Williamsburg Virginia
June 28-July 1, 2007

Motor neuropathy in the diabetic patient

MRSA evaluation and management

Homocysteine and diabetic foot pathology

Complication management in diabetic foot pathology

South Carolina podiatric medical Association
Annual scientific seminar
Myrtle Beach South Carolina
July 11-15, 2007

Evaluation and management of symptomatic neuropathy and a diabetic patient

Management of infection in a patient with diabetes

Ulcer management in a patient with diabetes

Evaluation and management of Charcot's joint disease

Motor neuropathy in a patient with diabetes

American podiatric medical Association
Annual scientific meeting
Philadelphia Pennsylvania
Thursday, August 16, 2007

Pharmacologic management of diabetic neuropathy

Socieded de Medicos Podiatris
Annual scientific meeting
Fajardo, Puerto Rico
August 9-12 2007

Role of homocysteine in diabetic foot pathology

Second MPJ pain

Evaluation and management of flatfoot deformity

Evaluation and management of heel pain

Fibromyalgia ND podiatric patient

Kilo diabetes and vascular research Foundation
35th annual scientific seminar
Current topics in diabetes, endocrinology and vascular disease
St. Louis Missouri
November 2-3, 2007

Aggressive management principals for diabetic neuropathy

Ohio State podiatric medical Association
Annual scientific conference
Easton Ohio
June 7-9, 2007

Evaluation and management of symptomatic diabetic neuropathy

"Super bones" annual scientific seminar
Atlantis resort, Bahamas
January 16-20, 2008

Homocysteine and diabetic foot pathology

New York State podiatric medical Association
Annual scientific meeting
New York City, New York
January 25-27

Elective surgery in the patient with diabetes

Evaluation and management of infection in the diabetic patient

Evaluation of neuropathy in the diabetic patient

American College of foot and ankle surgeons
Annual scientific seminar
Long Beach California
February 20-24, 2008

Pain management in the foot and ankle surgical patient

Medical legal considerations in bunion surgery

Current concepts in the management of diabetic neuropathy

Recent publications;

Case reports in the management of diabetic neuropathy
Allen M. Jacobs, David Allie, Gary Chandler, Gabriel Rodriguez
Vascular disease management November/ December, 2005

Soft tissue procedures with stabilization of medial arch pathology in the management of flexible flat foot deformity
Allen M Jacobs
Clinics and podiatric medicine and surgery
Volume 24, #4 2007

Minimizing legal risk with bunion procedures
Allen M. Jacobs DPM
Podiatry Today, April 2009

Evaluation and management of MRSA infection
Allen M. Jacobs DPM
Podiatry Today, August 2009

Remittive therapy in the management of symptomatic and nonsymptomatic diabetic neuropathy
Allen Jacobs DPM Wounds volume 21, #4 2009

Remittive therapy in the management of symptomatic and nonsymptomatic diabetic neuropathy
Vascular Disease Management volume 6, # 3 2009

Diabetic Peripheral Neuropathy
Peter Sheehan and Allen Jacobs
Wounds issue #4, April 2009

Perioperative Management Of the Patient with Rheumatoid Arthritis
Allen Mark Jacobs DPM
Clinics in Podiatric Medicine and Surgery (in press-2009)

Current status and activities 2019-2020

1. Full-time private practice	6400 Clayton Rd., St. Louis Missouri
2. Scientific co-chairperson:	Limb salvage and wound healing section Complex Cardiovascular Catheter Solutions Annual scientific meeting
3. Scientific co-chairperson:	Annual Scientific Conference Association of Physicians in Wound Healing
4. Editorial advisor;	Foot and Ankle Quarterly
5. Editorial board;	Clinics in Podiatric Medicine and Surgery
6. Faculty and lecturer:	Annual Scientific Conference American College of Foot and Ankle Surgeons
7. Scientific chairperson:	St. Louis Podiatry annual scientific sessions
8. Medical consultant:	BAKO diagnostic laboratories
9. Medical consultant;	Stryker orthopedics
10. Medical consultant:	Arche Healthcare
11. Scientific co-chairperson:	New Cardiovascular Horizons Annual scientific sessions/St. Louis Missouri
12. Medical editor:	Center for Podiatric Medical Education
13. Clinical researcher;	PERI (Professional Education and Research Institute)
14. Board of directors:	CMET (Council on Medical Education and Testing)
15. Board of directors:	APWH (Association of Physicians in Wound Healing)
16. Examiner:	American Board of Foot and Ankle Surgery

Current status: Board certifications 2019-2020

1. American Board of Foot and Ankle surgery (ABFAS)

   Board certification in foot, reconstructive surgery and ankle surgery

2. CMET (Council for Medical Education and Testing)

   Multispecialty board certification and wound evaluation and management

3. NIH

   Certification in research ethics

Current fellowship status 2019-2020

1. Fellow, American College of Foot and Ankle Surgeons
2. Fellow, Association of Physicians in Wound Healing
3. Fellow, Temple Univerity Philadelphia Pennsylvania

Recent awards

2018 **Wound care physician of the year**
Awarded by the Association of Physicians in Wound Healing (APWH)
This is an international association of MD's, DO's DPM's dedciated to the advancement of wound healing and limb salvage. Award for education, research, and clinical advancements in limb salvage and wound care.

2014 **Fellowship Status: Temple University Philadelphia Pennsylvania**
Awarded by Temple University for achievenment in research and education.
This was the first time that a DPM was awarded this status by the University

2010 **Lifetime Achievement Award and Selection to the Podiatry Hall of Fame**
Awarded by Podiatry Managment based upon a national vote of podiatric physicians throughout the United States. To this date, only 36 podiatrists have achieved this status.

Awards for state governments.

1. **Jay Nixon, Gov, Missouri**
   Lifetime achievement award for accomplishments in podiatry 2010

2. **William Clinton, Gov. Arkansas**
   "Arkansas Traveler" 1985
   Awarded for academic accomplishment in podiatry and podiatric education

3. **Michael Dukakis, Gov, Massachusettes**
   Achievements in podiatric education 1985
   On behalf of the massachusttes State Podiatry Society

Recent publications

Medial Column Soft Tissue Corrective Procedures in the Surgical Management Of Posterior Tibial Tendon Dysfunction
Jacobs AM
Clinics and Podiatric Medicine and Surgery 2015

Osteomyelitis associated with Charcot joint arthropathy
Rubin, LG and Jacobs, AM
Osteomyelitis of the foot and ankle
Springer 2015

Complications of Foot and Ankle Surgery 2018
Springer 2017
Chapter 1: Anatomy of complications
Jacobs

Use of an aseptically processed, dehydrated human amnion and chorion membrane improves likelihood and rate of healing in chronic diabetic foot ulcers:, A prospective randomized, multicenter clinical trial in 80 patients (multiple co-authors)
International Wound Journal volume 15, issue 6, 2018

Perioperative Management Of the Geriatric Patient
Clinics and Podiatric Medicine and Surgery 2019
(Multiple co-authors)

Lecture presentations at seminars

January 13, 14, 15, 16, 2011
Super bones annual meeting
Atlantis Bahamas

January 20, 21, 2011
Florida State Podiatric Medical Association
Orlando Florida

January 22, 23
Michigan State Podiatry Side He
Traverse City Michigan,

January 29, 2011
Granite medical Clinic
Columbus Ohio

February 18, 19, 2011
Georgia Podiatric Medical Association
Atlanta Georgia

February 25, 26, 2011
St. Louis Podiatry Seminar
St. Louis Missouri

March 5, 6, 2011
Midwest Podiatry Conference
Chicago Illinois

March 9, 10, 11
American College of Foot and Ankle Surgeons
Washington DC

March 12, 13, 2011
Northeast podiatric medical Association
Cleveland Ohio

March 31, April 1, 2, 2011
APWCA
Philadelphia Pennsylvania

April 9, 2011
Western Pennsylvania Hospital
Pittsburgh Pennsylvania

April 28, 29, 30, 2011
Southern exposure/Kent state University
Cincinnati Ohio

May 20, 2011
Kentucky Podiatric Medical Association
Lexington Kentucky

May 21, 22, 2011
Northeast podiatric Foundation

Albany New York

June 10, 11, 2011
International Academy of Insulin Resistance
Los Angeles California

June 17, 18, 2011
Florida Podiatric Medical Association
Boca Raton Florida

July 14, 15, 16, 2011
Virginia Podiatric Medical Association
Virginia Beach, Virginia

July 28, 29, 30, 31, 2011
American Podiatric Medical Association
Boston Massachusetts

August 2, 2011
St. Anthony's Hospital
St. Louis Missouri

August 26, 27, 28, 2011
Missouri Podiatric Medical Association
St. Louis Missouri

September 22, 23, 24, 25
Kent State College of Podiatric Medicine
Rye New York

October 1, 2011
Temple University College of Podiatry
Philadelphia Pennsylvania

October 12, 2011
North Carolina Podiatry Society
Greensboro North Carolina

October 14, 2011
Arkansas Podiatric Medical Association
Little Rock Arkansas

October 15, 2011
New York Podiatric Medical Association

October 16, 2011
Cornell University medical school
New York City, New York

October 21, 22, 23, 2011
Super bones West
Las Vegas Nevada

November 11, 12, 2011
Region 7, APMA
Vancouver produce Columbia

November 16, 17, 18, 2011

Desert Foot
Phoenix Arizona

November 19, 2011
Kilo Diabetes Association
St. Louis Missouri

December 1, 2011
New York Podiatric Medical Association
Buffalo New York

January 13, 2012
North Carolina State Podiatry Association
Pinehurst North Carolina

January 19, 20, 21, 2012
Florida State Podiatric Medical Association
Orlando Florida

January 27, 28, 29, 2012
New York State podiatric medical Association
York city, New York

February 9, 2012
Alabama State Podiatry Society
Birmingham Alabama

February 22, 23, 24, 25, 26
Kent state podiatry college
Southeast regional Meeting
Orlando Florida

March 1, 2, 3, 4, 2012
American College of Foot and Ankle Surgeons
Los Angeles California

March 9, 10, 11, 2012
Northeast Podiatric Medical Association
Cleveland Ohio

March 16, 17, 2012
St. Louis Podiatry Seminar
St. Louis Missouri

March 23, 24, 25, 2012
Connecticut State Podiatric Medical Association
Mystic Connecticut

March 29, 2012
American Professional Wound Care Association
Philadelphia Pennsylvania

March 30, 31, 32, 2012
Super bones
Atlantis, Bahamas

April 20, 21, 2012

Midwest Podiatry Seminar
Chicago Illinois

April 22, 2012
Kansas Podiatric Medical Association

April 26, 27, 28, 2012
Southern exposure/Kent state podiatry college
Cincinnati Ohio

May 2, 2012
Region 3, American Podiatric Medical Association
Atlantic City New Jersey

May 4, 5, 6, 2012
Northeastern Podiatric Foundation
Albany New York

May 11, 2012
Columbia medical school Limb Salvage
New York City New York

June 7, 2012
New cardiovascular horizons
New Orleans Louisiana

June 9, 10, 2012
Ohio Podiatric Medical Association
Columbus Ohio

July 18, 2012
Texas Podiatric Medical Association
Sugarland Texas

July 19, 2012
California Podiatric Medical Association
Sacramento California

August 17, 2012
American Podiatric Medical Association
Washington DC

September 21, 2012
New York State podiatric medical Association
Buffalo New York

September 22, 2012
Tennessee podiatric medical Association
Franklin Tennessee

September 27, 2017
Alabama Podiatric Medical Association

October 12, 2012
Iowa podiatric medical Association
Des Moines Iowa

October 6, 2012

Temple University College of Podiatry
Philadelphia Pennsylvania

October 12, 13 2012
Ohio College of Podiatric Medicine
Rye New York

October 17, 2012
Texas podiatric medical Association
Corpus Christi Texas

October 20, 2012
R. Consult Podiatric Medical Association
Ft. Smith Arkansas

October 26, 2012
Oklahoma Podiatric Medical Association

November 30, 31, 2012
Kilo Diabetes Foundation Annual Meeting
St. Louis Missouri

January 25, 26, 27, 2013
New York State Podiatric Medical Association

January 31, 2013
Texas Podiatric Medical Association
Dallas Texas

February 11, 12, 13, 14, 2013
American College of Foot and Ankle Surgeons
Las Vegas Nevada

February 20, 2013
Georgia Podiatric Medical Association
A. lead Georgia

March 6, 7, 8 2013
Kent State Podiaty College
Orlando Florida

March 9, 10
Northeastern Ohio Podiatry Society
Cleveland Ohio

March 15, 16, 2013
St. Louis Podiatry Seminar
St. Louis Missouri

March 21, 22, 23, 2013
Connecticut Podiatric Medical Association
Mystic Connecticut

April 4, 5, 6, 2013
Association of Physicians in Wound Healing
Newark New Jersey

April 18, 2013
NAPA Valley California

April 20, 21, 2013
Kentucky Podiatric Medical Association
Lexington Kentucky

April 25, 2013
Ohio Podiatric Medical Association
Columbus Ohio

May 2, 2013
Region 3 Scientific Meeting
Atlantic City New Jersey

May 12, 13, 2013
Save the Limb Save a Life
Orlando Florida

June 5, 6, 2013
New Cardiovascular Horizons
New Orleans, Louisiana

June 8, 2013
Ohio Podiatric Medical Association
Columbus Ohio

June 20, 21, 22, 2013
Virginia Podiatric Medical Association
Virginia Beach, Virginia

June 27, 2013
Diabetic Limb Salvage Seminar
Washington DC

June 28, 2013
Washington University school of medicine/wound care seminar
St. Louis Missouri

June 29, 2013
National Podiatric Medical Association
Miami Florida

May 3, 4, 2013
Northeastern Podiatric Foundation
Albany New York

August 22, 2013
Missouri State Podiatry Society
Kansas City Missouri

August 23, 24, 2013
Georgia State Podiatric Medical Association
Atlanta Georgia

September 22, 2013
Temple University School of Podiatry

Philadelphia Pennsylvania

October 4, 2013
Iowa State Podiatry Society
Des Moines Iowa

October 24, 2013
Northeastern Podiatry Foundation
Albany New York

October 30, 2013
Connecticut Podiatric Medical Association
Hartford Connecticut

November 9, 2013
Goldfarb Foundation scientific sessions
Philadelphia Pennsylvania

January 11, 12, 2014
North Carolina podiatric medical Association
Charlotte, North Carolina

January 24, 25, 26, 2014
New York State Podiatric Medical Association Annual Scientific Sessions

February 18, 19, 20, 21, 22, 2014
Kent state Podiatric Medical Association
Cincinnati Ohio

February 27, 28, 29, 2014
American College of Foot and Ankle Surgeons
Orlando Florida

March 7, 8, 9, 2014
Northwestern Podiatric Medical Association
Cleveland Ohio

March 28, 29, 2014
St. Louis Podiatry meeting
St. Louis Missouri

April 26, 27, 2014
Kentucky Podiatric Medical Association
Louisville Kentucky

May 1, 2, 3,
Southeast exposure Seminar
Cincinnati Ohio

September 20, 21, 2014
Temple University school of Podiatry
Philadelphia Pennsylvania

October 2, 2014
Iowa State Podiatry Annual Scientific Meeting
Des Moines Iowa

October 3, 2014
Minnesota State Podiatry Annual Scientific Sessions
Minneapolis, Minnesota

October 18, 19, 2014
New York State Podiatric Medical Association
Buffalo New York

October 25, 2014
Pennsylvania Podiatric Medical Association
Pennsylvania

January 23, 24, 25, 2015
New York State Podiatric Medical Association
New York City New York

February 20, 21, 22, 2015
American College of Foot and Ankle Surgeons
Annual Scientific Meeting
San Antonio Texas

February 25, 26, 27, 28, 2015
Kent State College of Podiatric Medicine
Cincinnati Ohio

March 7, 2015
New York College of Podiatric Medicine
New York City, New York

March 26, 27, 28, 2015
St. Louis Podiatry Seminar
St. Louis Missouri

April 17, 18, 2015
New York State Podiatry Association
Monroe New York

April 22, 23, 24, 25, 2015
Kent State College of Podiatric Medicine
Cincinnati Ohio

May 2,3, 2015
Northeastern Podiatric Foundation
Albany New York

June 4, 5, 6, 2015
Ohio Cardiac or Medical Association
Columbus Ohio

June 25, 26, 27, 2015
Virginia Podiatric Medical Association
Virginia Beach, regina

September 19, 2015
New Cardiovascular Horizons
St. Louis Missouri

September 20, 2015

Temple University College of Podiatry
Sylvia Pennsylvania

October 1, 2, 3, 4,
Association of Physicians in Wound Healing
Philadelphia Pennsylvania

October 16, 17, 2015
New York Podiatric Medical Association
Albany New York

October 23, 2015
Supersaver Annual Scientific Session
Cleveland Ohio

October 24, 2015
West Penn Hospital scientific sessions
Pittsburgh Pennsylvania

January 22, 23, 24, 2016
New York Podiatric Medical Association, annual scientific sessions

February 11, 12, 13, 14, 2016
American College of Foot and Ankle Surgeons
Annual scientific sessions

February 24, 25, 26, 27, 28, 2016
Kent state College of Podiatric Medicine
Cincinnati Ohio

March 11, 12, 13, 2016
Northeastern Podiatric Medical Association
Cleveland Ohio

March 18, 19, 2016
St. Louis Podiatry Seminar
St. Louis Missouri

April 9, 10, 2016
West Palm Beach Podiatric Medical Association
West Palm Beach Florida

September 17, 2016
New Cardiovascular Horizons
St. Louis Missouri

September 24, 2016
Temple University College of Podiatric Medicine
Philadelphia Pennsylvania

November 5, 2016
Kilo Diabetes seminar
St. Louis Missouri

November 12, 13, 2016
Georgia Podiatric Medical Association
Atlanta Georgia

December 14, 15, 16, 17, 2016
Kent State Podiatry College
Orlando Florida

February 27, 28, March 1, 2017
American College of Foot and Ankle Surgeons
Annual scientific sessions

March 11, 12, 2017
Northeastern Ohio Podiatric Medical Association
Cleveland Ohio

March 17, 18, 2017
St. Louis Podiatry Seminar
St. Louis Missouri

May 31, 2017
New Cardiovascular Horizons
New Orleans, Louisiana

August 6-7, 2017
Missouri Podiatric Medical Association
Kansas City Missouri

September 30, 2017
New Cardiovascular Horizons
St. Louis Missouri

January 13, 2018
Western Pennsylvania Hospital Scientific Conference
Pittsburgh Pennsylvania

January 19, 20, 21, 2018
New York State Podiatric Medical Association
New York City, New York

February 1, 2, 3, 4, 2018
Atlantis, Bahamas
St. Louis Podiatry Seminar/New York College of podiatric medicine

February 23, 24 2018
Georgia Podiatric Medical Association
Atlanta Georgia

March 10, 11, 2018
Northeastern Podiatric Medical Society
Cleveland Ohio "No-Nonsense" seminar

March 16, 17, 2018
St. Louis Missouri
St. Louis Podiatry seminar
St. Louis Missouri

March 22, 23, 24, 25, 2018
Annual Scientific Sessions
American College of Foot and Ankle Surgeons
Nashville Tennessee

May 3, 4, 5, 2018
Ontario Podiatric Medical Association
Toronto Canada

August 24, 25, 2018
St. Louis Podiatric Medical Association
St. Louis Missouri

September 7-September 8, 2018
American College of Lower Extremity Surgeons (ACLES)
Detroit Michigan

September 28, 2019
Colorado State Podiatric Medical Association
Denver Colorado

September 29, 2018
New Cardiovascular Horizons
St. Louis Missouri

October 12, 13, 14, 2018
Association of Physicians in Wound Healing/annual scientific conference
Philadelphia Pennsylvania

Recent publications

Medial Column Soft Tissue Corrective Procedures in the Surgical Management Of Posterior Tibial Tendon Dysfunction
Jacobs AM
Clinics and Podiatric Medicine and Surgery 2015

Osteomyelitis associated with Charcot joint arthropathy
Rubin, LG and Jacobs, AM
Osteomyelitis of the foot and ankle
Springer 2015

Complications of Foot and Ankle Surgery 2018
Springer 2017
Chapter 1: Anatomy of complications
Jacobs

Use of an aseptically processed, dehydrated human amnion and chorion membrane improves likelihood and rate of healing in chronic diabetic foot ulcers:, A prospective randomized, multicenter clinical trial in 80 patients (multiple co-authors)
International Wound Journal volume 15, issue 6, 2018

Perioperative Management Of the Geriatric Patient
Clinics and Podiatric Medicine and Surgery 2019
(Multiple co-authors)

UNITED STATES DISTRICT COURT
DISTRICT OF SOUTH CAROLINA
CHARLESTON DIVISION

KEITH LYNN AND JENNIFER LYNN, Plaintiffs, vs. UNITED STATES OF AMERICA, Defendant.	Case No. 2:20-cv-04277-JD

PLAINTIFFS' NOTICE OF COMPLIANCE AND CERTIFICATION OF DISCLOSURE

Plaintiffs Keith Lynn and Jennifer Lynn, by and through undersigned counsel, give notice that they have identified those persons whom they expect to call as experts at trial and certify that a written report prepared and signed by each such expert was served upon the Defendant United States of America, along with the summons and complaint in this action. Plaintiffs reserve the right to disclose any additional expert(s) as permitted by the Federal Rules of Civil procedure, including at trial for purposes of rebuttal and in response to Defendant's expert disclosures due on September 6, 2021.

IDENTIFICATION OF EXPERTS

A. The following individuals are medical care providers and are expected to testify regarding their observations. These individuals and entities may provide information or testimony regarding the injuries sustained by Plaintiff Keith Lynn, the treatment for said injuries, the cause of said injuries, the damages from said injuries, the physical limitations of said injuries, the need for further medical treatment for said injuries, and the reasonable and customary cost of treatment for said injuries.

Plaintiffs incorporate by reference the treating physicians listed in their answers to the Court's Local Civil Rule 26.03 interrogatories, filed and served on June 15, 2021.

B. The following individuals are those whom Plaintiffs have retained or specially employed to provide expert testimony. Further, in accordance with Federal Rule of Civil Procedure 26(a)(2)(B), the undersigned hereby certifies that opposing counsel has been served with the expert reports required by Rule 26(a)(2)(B).

Allen Mark Jacobs DPM, FACFAS FAPWH
6400 Clayton Road, Suite 402
St. Louis, MO 63117
(314) 367-6545

Respectfully submitted,

TINKLER LAW FIRM LLC

/s/ Paul E. Tinkler
Paul E. Tinkler (D.S.C. No. 4108)
William P. Tinkler (D.S.C. No. 11794)
P.O. Box 366
Charleston, SC 29402
(843) 853-5203
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Stephen F. DeAntonio (D.S.C. No. 1049)
DeANTONIO LAW FIRM, LLC
P.O. Box 30069
Charleston, SC 29417
sdeantonio@deanlawfirm.com

August 6, 2021

Counsel for Plaintiffs

CERTIFICATE OF SERVICE

I hereby certify that on August 6, 2021, I served **PLAINTIFFS' NOTICE OF COMPLIANCE AND CERTIFICATION OF DISCLOSURE** to Defendant's counsel of record.

/s/ Paul E. Tinkler
Paul E. Tinkler (D.S.C. No. 4108)

IN THE UNITED STATES DISTRIC COURT
FOR THE DISTRICT OF SOUTH CAROLINA
CHARLESTON DIVISION

Keith Lynn and Jennifer Lynn,	)	
	)	
Plaintiffs,	)	CA No.: 2:20-cv-4277-JD
v.	)	
	)	
	)	
United States of America,	)	
Defendant.	)	
	)	

DISCLOSURE OF EXPERT WITNESS BY DEFENDANT; F.R.C.P. 26(a)(2)(B):

1. *Dr. Mark Jackson*

Defendant will provide plaintiff with the Curriculum Vitae of Dr. Mark Jackson, St. Francis Hospital, and Carolina Vein Care and Aesthetics, both of Greenville, South Carolina. When called as witnesses by the government, it is intended that Dr. Jackson will be qualified by the Court to testify as an expert witness in the field of Vascular Surgery. A written report will be forthcoming to the plaintiff that shall contain all opinions, the data relied on to form opinions, and copies of any exhibits to be used. Dr. Jackson is to be compensated at a rate of $375.00 per hour to review the case or be deposed, and $400.00 per hour for court testimony plus travel expenses or $2,250.00 per day of trial testimony. On information and belief, Dr. Jackson has not testified as an expert witness in a deposition or trial over the past four years.

2. *Dr. Jan Fritz*

Defendant will provide plaintiff with the Curriculum Vitae of Dr. Jan Fritz, New York University Langone Health Hospital, New York, NY. When called as witnesses by the government, it is intended that Dr. Fritz will be qualified by the Court to testify as an expert witness in the field of Radiology. A written report will be forthcoming to the plaintiff that shall contain all opinions, the data relied on to form opinions, and copies of any exhibits to be used.

Dr. Fritz is to be compensated at a rate of $500.00 per hour to review the case, $500.00 per hour for deposition or $5,000.00 per day, and $500.00 per hour for court testimony plus travel expenses or $5,000.00 per day of trial testimony. On information and belief, Dr. Fritz has testified as an expert witness in a deposition or trial over the past four years and his list of cases is being provided to plaintiff.

3. *Dr. John Womack*

Defendant will provide plaintiff with the Curriculum Vitae of Dr. John Womack, Piedmont Orthopedic Associates, Greenville, South Carolina. When called as witnesses by the government, it is intended that Dr. Womack will be qualified by the Court to testify as an expert witness in the field of Orthopedic Surgery specializing in Foot and Ankle. A written report will be forthcoming to the plaintiff that shall contain all opinions, the data relied on to form opinions, and copies of any exhibits to be used. Dr. Womack is to be compensated at a rate of $400.00 per hour to review the case, $550.00 per hour to be deposed, and $400.00 per hour for court testimony or $3,200.00 per day of trial testimony. On information and belief, Dr. Womack has not testified as an expert witness in a deposition or trial over the past four years.

4. *Dr. Rick Delmonte*

Defendant will provide plaintiff with the Curriculum Vitae of Dr. Rick Delmonte, New York University Langone Health Hospital, New York, NY. When called as witnesses by the government, it is intended that Dr. Delmonte will be qualified by the Court to testify as an expert witness in the field of Podiatric Medicine. A written report will be forthcoming to the plaintiff that shall contain all opinions, the data relied on to form opinions, and copies of any exhibits to be used. Dr. Delmonte is to be compensated at a rate of $600.00 per hour to review the case or be deposed, and $5,000.00 per half day for court testimony. On information and belief, Dr. Jackson has not testified as an expert witness in a deposition or trial over the past four years.

M. RHETT DEHART
ACTING UNITED STATES ATTORNEY

BY:____s/Lee E. Berlinsky_____
LEE E. BERLINSKY (#5443)
Assistant U.S. Attorney
151 Meeting Street, Suite 200
Charleston, S.C. 29401
Phone: (843) 266-1667
E-Mail: Lee.Berlinsky@usdoj.gov

September 6, 2021

UNITED STATES DISTRICT COURT
DISTRICT OF SOUTH CAROLINA
CHARLESTON DIVISION

KEITH LYNN AND JENNIFER LYNN, Plaintiffs, vs. UNITED STATES OF AMERICA, Defendant.	Case No. 2:20-cv-04277-JD

PLAINTIFFS' AMENDED NOTICE OF COMPLIANCE AND CERTIFICATION OF DISCLOSURE

Plaintiffs Keith Lynn and Jennifer Lynn, by and through undersigned counsel, give notice that they have identified those persons whom they expect to call as experts at trial and certify that a written report prepared and signed by each such expert (except as otherwise indicated below) was served upon the Defendant United States of America. Plaintiffs reserve the right to disclose any additional expert(s) as permitted by the Federal Rules of Civil procedure, including at trial for purposes of rebuttal and in response to Defendant's expert disclosures due on January 31, 2022.

IDENTIFICATION OF EXPERTS

A. The following individuals are medical care providers and are expected to testify regarding their observations. These individuals and entities may provide information or testimony regarding the injuries sustained by Plaintiff Keith Lynn, the treatment for said injuries, the cause of said injuries, the damages from said injuries, the physical limitations of said injuries, the need for further medical treatment for said injuries, and the reasonable and customary cost of treatment for said injuries.

Plaintiffs incorporate by reference the treating physicians listed in their answers to the Court's Local Civil Rule 26.03 interrogatories, filed and served on June 15, 2021.

B. The following individuals are those whom Plaintiffs have retained or specially employed to provide expert testimony. Further, in accordance with Federal Rule of Civil Procedure 26(a)(2)(B), the undersigned hereby certifies that opposing counsel has been served with the expert reports required by Rule 26(a)(2)(B), except where the report is indicated as forthcoming.

Allen Mark Jacobs DPM, FACFAS FAPWH
6400 Clayton Road, Suite 402
St. Louis, MO 63117
(314) 367-6545

Dr. Oliver G. Wood, Jr. (Report Forthcoming)
PO Box 24677
Columbia, SC 29224
(803) 736-1300

Respectfully submitted,

TINKLER LAW FIRM LLC

/s/ William P. Tinkler
Paul E. Tinkler (D.S.C. No. 4108)
William P. Tinkler (D.S.C. No. 11794)
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Stephen F. DeAntonio (D.S.C. No. 1049)
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P.O. Box 30069
Charleston, SC 29417

sdeantonio@deanlawfirm.com

January 3, 2022

Counsel for Plaintiffs

CERTIFICATE OF SERVICE

I hereby certify that on January 3, 2022, I served **PLAINTIFFS' AMENDED NOTICE OF COMPLIANCE AND CERTIFICATION OF DISCLOSURE** to Defendant's counsel of record.

/s/ William P. Tinkler
William P. Tinkler (D.S.C. No. 11794)

TINKLER LAW
PO Box 366, Charleston, SC 29402 | www.tinklerlaw.com

Paul Tinkler
paultinkler@tinklerlaw.com

William Tinkler
williamtinkler@tinklerlaw.com

October 7, 2019

VIA US MAIL (CERTIFIED RETURN RECEIPT)
Tammy Kennedy, Esquire
Office of Chief Counsel
VA Regional Office
3322 West End Avenue, Suite 509
Nashville, TN 37203

RE: Tort Claim Form 95
Keith Edward Lynn (DOB) [redacted]
Jennifer Lynn (DOB) [redacted]

Dear Ms. Kennedy,

Enclosed please find a Tort Claim Form 95 that I am serving on behalf of my clients Keith Edward Lynn and his wife, Jennifer Lynn. I am also attaching portions of the VA medical records related to the claim and a list of witnesses as referenced on the forms. I would appreciate your filing both of the forms at your convenience.

Please do not hesitate to contact me should you have any questions.

Thanking you for your kind assistance, I am

Sincerely,

Paul E. Tinkler

Enclosures:
Tort Claim Form 95 (Keith Lynn)
Tort Claim Form 95 (Jennifer Lynn)
Partial VA medical records (Keith Lynn)
Witness List
cc: Stephen D'Antonio, Esquire
Keith and Jennifer Lynn

CLAIM FOR DAMAGE, INJURY, OR DEATH	INSTRUCTIONS: Please read carefully the instructions on the reverse side and supply information requested on both sides of this form. Use additional sheet(s) if necessary. See reverse side for additional instructions.	FORM APPROVED OMB NO. 1105-0008

1. Submit To Appropriate Federal Agency:	2. Name, Address of claimant and claimant's personal representative, if any. (See instructions on reverse.) (Number, Street, City, State and Zip Code)
Ralph H. Johnson VA Medical Center 109 Bee Street Charleston, SC 29401	Keith Edward Lynn 108 Rudolph Court Ridgeville, SC 29472

3. TYPE OF EMPLOYMENT	4. DATE OF BIRTH	5. MARITAL STATUS	6. DATE AND DAY OF ACCIDENT	7. TIME (A.M. OR P.M.)
☒ MILITARY ☐ CIVILIAN	[redacted]	Married	January 17, 2019	

8. Basis of Claim (State in detail the known facts and circumstances attending the damage, injury, or death, identifying persons and property involved, the place of occurrence and the cause thereof. Use additional pages if necessary.)

Failure to diagnose Osteomyelitis resulting in an above the knee amputation. (medical records attached hereto associated with the amputation)

9. **PROPERTY DAMAGE**

NAME AND ADDRESS OF OWNER, IF OTHER THAN CLAIMANT (Number, Street, City, State, and Zip Code).

BRIEFLY DESCRIBE THE PROPERTY, NATURE AND EXTENT OF DAMAGE AND THE LOCATION WHERE PROPERTY MAY BE INSPECTED. (See instructions on reverse side.)

10. **PERSONAL INJURY/WRONGFUL DEATH**

STATE NATURE AND EXTENT OF EACH INJURY OR CAUSE OF DEATH, WHICH FORMS THE BASIS OF THE CLAIM. IF OTHER THAN CLAIMANT, STATE NAME OF INJURED PERSON OR DECEDENT.

Failure to diagnose Osteomyelitis resulting in an above the knee amputation. (medical records attached hereto associated with the amputation)

11. **WITNESSES**

NAME	ADDRESS (Number, Street, City, State, and Zip Code)
See attached	See attached

12. (See instructions on reverse.) **AMOUNT OF CLAIM** (In dollars)

12a. PROPERTY DAMAGE	12b. PERSONAL INJURY	12c. WRONGFUL DEATH	12d. TOTAL (Failure to specify may cause forfeiture of your rights.)
	$1,000,000		

I CERTIFY THAT THE AMOUNT OF CLAIM COVERS ONLY DAMAGES AND INJURIES CAUSED BY THE INCIDENT ABOVE AND AGREE TO ACCEPT SAID AMOUNT IN FULL SATISFACTION AND FINAL SETTLEMENT OF THIS CLAIM

13a. SIGNATURE OF CLAIMANT (See instructions on reverse side.)	13b. Phone number of person signing form	14. DATE OF SIGNATURE
Keith Edward Lynn	843-291-5231	October 4, 2019

CIVIL PENALTY FOR PRESENTING FRAUDULENT CLAIM	CRIMINAL PENALTY FOR PRESENTING FRAUDULENT CLAIM OR MAKING FALSE STATEMENTS
The claimant is liable to the United States Government for the civil penalty of not less than $5,000 and not more than $10,000, plus 3 times the amount of damages sustained by the Government. (See 31 U.S.C. 3729.)	Fine of not more than $10,000 or imprisonment for not more than 5 years or both. (See 18 U.S.C. 287, 1001.)

95-109 NSN 7540-00-634-4046 STANDARD FORM 95
PRESCRIBED BY DEPT. OF JUSTICE
28 CFR 14.2

INSURANCE COVERAGE

In order that subrogation claims may be adjudicated, it is essential that the claimant provide the following information regarding the insurance coverage of his vehicle or property.

15. Do you carry accident insurance? ☐ Yes If yes, give name and address of insurance company (Number, Street, City, State, and Zip Code) and policy number. ☐ No

16. Have you filed a claim on your insurance carrier in this instance, and if so, is it full coverage or deductible? ☐Yes ☐No

17. If deductible, state amount.

18. If a claim has been filed with your carrier, what action has your insurer taken or proposed to take with reference to your claim? (It is necessary that you ascertain these facts.)

19. Do you carry public liability and property damage insurance? ☐ Yes If yes, give name and address of insurance carrier (Number, Street, City, State, and Zip Code). ☐ No

INSTRUCTIONS

Claims presented under the Federal Tort Claims Act should be submitted directly to the "appropriate Federal agency" whose employee(s) was involved in the incident. If the incident involves more than one claimant, each claimant should submit a separate claim form..

Complete all items - Insert the word NONE where applicable.

A CLAIM SHALL BE DEEMED TO HAVE BEEN PRESENTED WHEN A FEDERAL AGENCY RECEIVES FROM A CLAIMANT, HIS DULY AUTHORIZED AGENT, OR LEGAL REPRESENTATIVE, AN EXECUTED STANDARD FORM 95 OR OTHER WRITTEN NOTIFICATION OF AN INCIDENT, ACCOMPANIED BY A CLAIM FOR MONEY DAMAGES IN A **SUM CERTAIN** FOR INJURY TO OR LOSS OF PROPERTY, PERSONAL INJURY, OR DEATH ALLEGED TO HAVE OCCURRED BY REASON OF THE INCIDENT. THE CLAIM MUST BE PRESENTED TO THE APPROPRIATE FEDERAL AGENCY WITHIN **TWO YEARS** AFTER THE CLAIM ACCRUES.

Failure to completely execute this form or to supply the requested material within two years from the date the claim accrued may render your claim invalid. A claim is deemed presented when it is received by the appropriate agency, not when it is mailed.

If instruction is needed in completing this form, the agency listed in item #1 on the reverse side may be contacted. Complete regulations pertaining to claims asserted under the Federal Tort Claims Act can be found in Title 28, Code of Federal Regulations, Part 14. Many agencies have published supplementing regulations. If more than one agency is involved, please state each agency.

The claim may be filed by a duly authorized agent or other legal representative, provided evidence satisfactory to the Government is submitted with the claim establishing express authority to act for the claimant. A claim presented by an agent or legal representative must be presented in the name of the claimant. If the claim is signed by the agent or legal representative, it must show the title or legal capacity of the person signing and be accompanied by evidence of his/her authority to present a claim on behalf of the claimant as agent, executor, administrator, parent, guardian or other representative.

If claimant intends to file for both personal injury and property damage, the amount for each must be shown in item #12 of this form.

The amount claimed should be substantiated by competent evidence as follows:

(a) In support of the claim for personal injury or death, the claimant should submit a written report by the attending physician, showing the nature and extent of injury, the nature and extent of treatment, the degree of permanent disability, if any, the prognosis, and the period of hospitalization, or incapacitation, attaching itemized bills for medical, hospital, or burial expenses actually incurred.

(b) In support of claims for damage to property, which has been or can be economically repaired, the claimant should submit at least two itemized signed statements or estimates by reliable, disinterested concerns, or, if payment has been made, the itemized signed receipts evidencing payment.

(c) In support of claims for damage to property which is not economically repairable, or if the property is lost or destroyed, the claimant should submit statements as to the original cost of the property, the date of purchase, and the value of the property, both before and after the accident. Such statements should be by disinterested competent persons, preferably reputable dealers or officials familiar with the type of property damaged, or by two or more competitive bidders, and should be certified as being just and correct.

***(d)* Failure to specify a sum certain will render your claim invalid and may result in forfeiture of your rights.**

PRIVACY ACT NOTICE

This Notice is provided in accordance with the Privacy Act, 5 U.S.C. 552a(e)(3), and concerns the information requested in the letter to which this Notice is attached.

A. *Authority:* The requested information is solicited pursuant to one or more of the following: 5 U.S.C. 301, 28 U.S.C. 501 et seq., 28 U.S.C. 2671 et seq., 28 C.F.R. Part 14.

B. *Principal Purpose:* The information requested is to be used in evaluating claims.

C. *Routine Use:* See the Notices of Systems of Records for the agency to whom you are submitting this form for this information.

D. *Effect of Failure to Respond:* Disclosure is voluntary. However, failure to supply the requested information or to execute the form may render your claim "invalid".

PAPERWORK REDUCTION ACT NOTICE

This notice is solely for the purpose of the Paperwork Reduction Act, 44 U.S.C. 3501. Public reporting burden for this collection of information is estimated to average 6 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Director, Torts Branch, Attention: Paperwork Reduction Staff, Civil Division, U.S. Department of Justice, Washington, D.C. 20530 or to the Office of Management and Budget. Do not mail completed form(s) to these addresses.

SF 95 BACK

CLAIM FOR DAMAGE, INJURY, OR DEATH	INSTRUCTIONS: Please read carefully the instructions on the reverse side and supply information requested on both sides of this form. Use additional sheet(s) if necessary. See reverse side for additional instructions.	FORM APPROVED OMB NO. 1105-0008

1. Submit To Appropriate Federal Agency:	2. Name, Address of claimant and claimant's personal representative, if any. (See instructions on reverse.) (Number, Street, City, State and Zip Code)
Ralph H. Johnson VA Medical Center 109 Bee Street Charleston, SC 29401	Jennifer Lynn 108 Rudolph Court Ridgeville, SC 29472

3. TYPE OF EMPLOYMENT	4. DATE OF BIRTH	5. MARITAL STATUS	6. DATE AND DAY OF ACCIDENT	7. TIME (A.M. OR P.M.)
☐ MILITARY ☒ CIVILIAN	[redacted]	Married	January 17, 2019	

8. Basis of Claim (State in detail the known facts and circumstances attending the damage, injury, or death, identifying persons and property involved, the place of occurrence and the cause thereof. Use additional pages if necessary.)

Loss of consortium due to injury to husband.

9. PROPERTY DAMAGE

NAME AND ADDRESS OF OWNER, IF OTHER THAN CLAIMANT (Number, Street, City, State, and Zip Code).

BRIEFLY DESCRIBE THE PROPERTY, NATURE AND EXTENT OF DAMAGE AND THE LOCATION WHERE PROPERTY MAY BE INSPECTED. (See instructions on reverse side.)

10. PERSONAL INJURY/WRONGFUL DEATH

STATE NATURE AND EXTENT OF EACH INJURY OR CAUSE OF DEATH, WHICH FORMS THE BASIS OF THE CLAIM. IF OTHER THAN CLAIMANT, STATE NAME OF INJURED PERSON OR DECEDENT.

See # 8

11. WITNESSES

NAME	ADDRESS (Number, Street, City, State, and Zip Code)
See attached	See attached

12. (See instructions on reverse.) AMOUNT OF CLAIM (In dollars)

12a. PROPERTY DAMAGE	12b. PERSONAL INJURY	12c. WRONGFUL DEATH	12d. TOTAL (Failure to specify may cause forfeiture of your rights.)
	$1,000,000		

I CERTIFY THAT THE AMOUNT OF CLAIM COVERS ONLY DAMAGES AND INJURIES CAUSED BY THE INCIDENT ABOVE AND AGREE TO ACCEPT SAID AMOUNT IN FULL SATISFACTION AND FINAL SETTLEMENT OF THIS CLAIM

13a. SIGNATURE OF CLAIMANT (See instructions on reverse side.)	13b. Phone number of person signing form	14. DATE OF SIGNATURE
Jennifer Beckett-Lynn	843-291-5231	October 4, 2019

CIVIL PENALTY FOR PRESENTING FRAUDULENT CLAIM

The claimant is liable to the United States Government for the civil penalty of not less than $5,000 and not more than $10,000, plus 3 times the amount of damages sustained by the Government. (See 31 U.S.C. 3729.)

CRIMINAL PENALTY FOR PRESENTING FRAUDULENT CLAIM OR MAKING FALSE STATEMENTS

Fine of not more than $10,000 or imprisonment for not more than 5 years or both. (See 18 U.S.C. 287, 1001.)

95-109 NSN 7540-00-634-4046 STANDARD FORM 95 PRESCRIBED BY DEPT. OF JUSTICE 28 CFR 14.2

Attachment to Form 95

Keith Lynn: DOB [redacted].

Witnesses:

Keith Lynn
108 Rudolph Court
Ridgeville, SC 29472
843-291-5231

Jennifer Lynn
108 Rudolph Court
Ridgeville, SC 29472
843-291-5231

Rahn A. Ravenell, MD
Podiatrist
180 Wingo Way #201
Mt. Pleasant, SC 29464
843-253-4066

Otis E. Engelman, MD
Attending Physician
Ralph H. Johnson VA Medical Center
109 Bee Street
Charleston, SC 29401
843-253-4066

Debbie L. Byron, MD
Podiatrist
Ralph H. Johnson VA Medical Center
109 Bee Street
Charleston, SC 29401
843-253-4066

William Hernandez-Alicea, MD
Attending Physician
Ralph H. Johnson VA Medical Center
109 Bee Street
Charleston, SC 29401
843-253-4066

Thomas Brothers, MD
Attending Surgeon
Ralph H. Johnson VA Medical Center
109 Bee Street
Charleston, SC 29401
843-253-4066

John Mcalhany, MD
Attending Physician
Ralph H. Johnson VA Medical Center
109 Bee Street
Charleston, SC 29401
843-253-4066

Peter A. Rosenthal, MD
Staff Radiologist
Ralph H. Johnson VA Medical Center
Charleston, SC 29401
843-253-4066

Any and all physicians who treated Keith Lynn at the Ralph H. Johnson VA Medical Center. Please refer to all of Mr. Lynn's medical records at the VA.

UNITED STATES DISTRICT COURT
DISTRICT OF SOUTH CAROLINA
CHARLESTON DIVISION

KEITH LYNN AND JENNIFER LYNN,
Plaintiffs,
vs. CASE NO. 2:20-cv-4277-JD
UNITED STATES OF AMERICA,
Defendant.

VIDEOCONFERENCE
DEPOSITION OF: ALLEN MARK JACOBS, DPM

DATE: March 11, 2022

TIME: 2:05 p.m.

LOCATION: 6400 Clayton Road
Suite 402
St. Louis, MO 63117

TAKEN BY: Counsel for the Defendant

REPORTED BY: KAREN NELLIUS, RPR
(Appearing via videoconference)

APPEARANCES OF COUNSEL:

ATTORNEYS FOR PLAINTIFFS
KEITH LYNN AND JENNIFER LYNN:

TINKLER LAW FIRM, LLC
BY: WILLIAM P. TINKLER
(Appearing via videoconference)
571 Savannah Highway
Charleston, SC 29407
843-853-5203
Williamtinkler@tinklerlaw.com

DEANTONIO LAW FIRM, LLC
BY: STEPHEN F. DEANTONIO
(Appearing via videoconference)
3 Gamecock Avenue
Suite 304A
Charleston, SC 29407
843-577-8080
Sdeantonio@deanlawfirm.com

ATTORNEYS FOR THE DEFENDANT
UNITED STATES OF AMERICA:
UNITED STATES DEPARTMENT OF JUSTICE
BY: LEE E. BERLINKSY
(Appearing via videoconference)
151 Meeting Street
Suite 200
Charleston, SC 29401
843-266-1679
Lee.berlinsky@usdoj.gov

(INDEX AT REAR OF TRANSCRIPT)

ALLEN MARK JACOBS, DPM,
being first duly sworn, testified as follows:

EXAMINATION

BY MR. BERLINSKY:

Q. Good afternoon, Dr. Jacobs. My name is Lee Berlinsky. I'm a United States attorney. I'm in Charleston, South Carolina. I noticed your deposition because you are identified as an expert witness in the case of Mr. Lynn versus the United States.

Are you familiar with that lawsuit and your role as an expert?

A. Yes.

Q. Okay. I'll talk as fast as I can. We have a court reporter, Karen, who is obviously on this same WebEx conference, and I would just ask a couple of housekeeping matters to help Karen take a good stenographic report.

If you would wait until I finish my question before you begin your answer, that would be greatly appreciated so that we don't cross communicate. Is that fair?

A. Yes.

(DEFENDANT EXHIBIT 1, DECLARATION OF ALLEN MARK JACOBS DPM, FACFAS, FAPWH AND CV, was

marked for identification.)
BY MR. BERLINSKY:
Q. I sent out an Exhibit Number 1, which is your Declaration and attached CV. Did you receive that?
A. Yes.
Q. Okay.
MR. BERLINSKY: Karen, do you have a copy of that for the record?
REPORTER: Yes, I do.
MR. BERLINSKY: Paul and Steve, if there is no objection, I'm going at some point during the flow of this deposition to ask that that be offered as Exhibit 1. Okay?
MR. TINKLER: No objection.
BY MR. BERLINSKY:
Q. I want to go through your resume very quickly, Dr. Jacobs. It's quite impressive and quite long. I think you noted that you've been doing this for 40 years; is that right?
A. Yes.
Q. Even up until today you have some surgery to perform. So you are active?
A. I am.
Q. Okay. What I have charted down was a

56-page resume with an additional 32 pages, give or take, for updates since 2009. Does that sound familiar to what you think is representative of your most current CV or has it been updated?

A. No. That's my most current CV.

Q. Thank you.

You are a doctor in podiatric medicine; is that fair?

A. Yes.

Q. I note that you are in St. Louis, which is part of Missouri. In your practice, are you licensed in any states other than Missouri?

A. I am not.

Q. Okay. Tell me what is the specific scope of podiatry medicine, at least in St. Louis? And then I'm going to ask you if it's any different in South Carolina just while we get started on this.

A. I don't know what the scope of practice is in South Carolina.

Q. Okay.

A. In Missouri it would be foot, ankle, and lower leg.

Q. In Missouri are you able to perform procedures above the ankle?

A. Yes.
Q. Okay. And you are unaware as to whether or not in South Carolina a podiatrist is allowed to perform surgeries and procedures above the ankle?
A. I am not.
Q. Okay. Just so the record is clear, you are not familiar with the South Carolina law on that issue; is that fair?
A. That's correct.
Q. Okay. Did you provide a fee schedule to Mr. Lynn's attorneys in anticipation of serving as an expert witness?
A. I would think.
Q. And what are your current rates? And if you want to break that down to an hourly rate or a deposition rate or a trial rate.
A. I don't have that sheet with me. I'm certain my girls provided it to plaintiffs' counsel. I would think they can provide you with a copy or I can obtain one if you need one.
Q. We will need one because the federal rules provide a requirement that that information be provided.
MR. TINKLER: I do have that. I can

get it to you, Lee.
BY MR. BERLINSKY:
Q. Additionally, there is a requirement to list cases that you have either testified in or been deposed in over the last four years.
Dr. Jacobs, have you provided a list to counsel for the plaintiff?
A. I don't know if he was provided one or not, but, again, if that's not available, we can provide one.
Q. Okay. I'll just ask you a few general questions since that information is not readily available to you. Do you know if you have sent any invoices for payments that have not been made yet?
A. I don't. I don't know if the girls had sent an invoice for preparation time for the deposition, but I would think that would be the only invoice.
Q. Okay. Do you know if you get a daily rate for a deposition or is it an hourly rate?
A. It's -- I'm not sure. I think we charge $2,500, maybe, for a deposition. $2,000 or $2,500 maybe.
Q. Okay. Do you send the bill through your practice or do you have a separate entity that

you perform expert services for that is run differently than your medical office?

A. I believe it's part of my practice. I don't have any other businesses.

Q. Okay. And then just a general question, if you know the answer to this: What is the percentage of income between serving as an expert and serving as a podiatrist, if you have that breakdown?

A. I don't. I'm in full-time private practice, if that will help, but I don't know the percentage. I would think it would be well less than 10 percent.

Q. Okay. Do you know just generally how many times you have served as an expert in the past?

A. Many. I don't have an exact number, but I've done many depositions. I've been to court a number of times, and I have reviewed many, many cases over the years.

Q. Would it be more than 100?

A. That I've reviewed?

Q. Yes, sir.

A. I would think so.

Q. Okay. Would it be more than 500?

A. No.
Q. Okay. Have you yourself ever been sued?
A. Oh, yes.
Q. Approximately how many times?
A. I would think five or six times in my career.
Q. Okay. Are there any active lawsuits against you personally?
A. No. And I've never had a judgment or a settlement of any case. Anytime I've ever been sued, it's been withdrawn.
Q. Other than the case that we're working on here on behalf of Mr. Lynn, how many active cases do you have at the moment where you are an expert?
A. I don't know. I would say at least 10, less than 20, I suppose, but there is a number. As you know, these things drag on for years and years.
Q. Okay. If we were to send an inquiry to plaintiffs' counsel on those questions that you are unable to answer today, would you be able to get to those answers at some point?
A. I would think so.
Q. Okay. Well, I just don't want to

disrupt the deposition now for you to start fumbling around to get those answers. It just doesn't seem to make much sense for the flow of productivity. Is that fair?

A. Yes.

Q. Okay. As far as your testimony in court or at a deposition, let's say, have you ever been advised by an attorney that has hired you that your opinions have not been allowed or been discredited by the court?

A. Never.

Q. Okay. Have you ever testified in an area of expertise other than in podiatry?

A. I don't believe so.

Q. Do you host any social media websites or podcasts that are relevant to the field of podiatry?

A. I don't host any social media sites of any type. I do have an online educational center. It's called the Center For Podiatric Education. It's a free educational website for podiatric physicians for postgraduate education.

Q. Okay. I don't want to go too far into the weeds on that, but you say it's a free website. Do you have to have a license to practice to

subscribe to that?

A. No.

Q. It's just open to the general public?

A. It is.

Q. Okay. How often do you update the materials on that website?

A. I've more or less discontinued updating it. So I would say the last time I put a lecture up was probably two or three years ago. I do most of my educational work now for an organization called Continuing Medical Education Online.

Q. Okay.

A. And I do that regularly.

Q. I indicated earlier, it looks like there is about 88 pages of CV, which is quite impressive. Running through that without spending a lot of time with respect to the fact that you are going to have a surgery at 3:00 in your time zone, just tell me, were there any articles or publications that you've been involved in that you refer to directly related to this case?

A. Just in a general sense. I'm fairly well published in the area of infections, Charcot's joint disease, and diabetic foot. I'm sure there is -- and I think there are probably some more that

have not made it. I pretty much stopped maintaining my CV. I just don't keep it up anymore. I'm sort of at the end of my career, and I really don't spend a good deal of time adding, but I assure you I continue publishing on a regular basis, and I probably should keep it up, but I don't maintain it.

Q. You are fairly well published and have experience, knowledge, and training in infections. Does that extend beyond, let's say, osteomyelitis?

A. Yes. Soft tissue and bone infection.

Q. Okay. Do you do much work in the field of necrotizing soft tissue infections?

A. Well, I have one patient in house now that I'm treating with a necrotizing infection of the foot. Of the leg, actually. I had one earlier this year that resulted in a leg amputation. So actual necrotizing fascial infections are not common, but I see several a year. Not tons. My practice is heavily weighted in diabetic foot. It fell that way. It wasn't intentional. So I probably have a bit more experience in that area than the average podiatrist would.

Q. Have you ever offered any expert opinions regarding the necrotizing fascitis that

you mentioned?

A. I don't think so.

Q. Okay. If you would look at Exhibit Number 1, the Declaration.

A. Yes.

Q. If you look at the back page, would you agree with me that your signature is on that?

A. It is.

Q. Okay. And it's dated December 2nd, 2020. Do you agree with that?

A. It is.

Q. Okay. I just want to focus a little bit of our testimony at the moment on this Declaration. In relation to the date it was signed, when was it prepared?

A. When?

Q. Yes, sir.

A. I have no idea.

Q. Okay. Do you know who prepared it?

A. I would assume plaintiff's counsel did based on a report that I submitted to him.

Q. Is there a report that you've written that is different than this Declaration?

A. There probably is a report somewhere that I've given him, yes. It's my style to review

records, speak on the telephone, and then at some point submit a written document.

Q. Okay.

MR. BERLINSKY: I don't think I've seen a copy of that. We can go off the record or I can just ask.

Paul, do you know anything about this written report?

MR. TINKLER: I'm just going from a vague recollection. We were required to file a formal declaration, as I recall it, in conjunction with filing, and I think he submitted something to us that we just put in this format, is what I'm recalling.

MR. BERLINSKY: Okay. Well, let's do this. I want to keep going with the deposition. At some point, I'll make a request for that report, and if there is a reason to re-depose Dr. Jacobs, is that fair that we try to get him back online at some point down the road?

MR. TINKLER: Yeah.

MR. BERLINSKY: All right. Thanks.

BY MR. BERLINSKY:

Q. So when you are looking at this -- Dr. Jacobs, we'll go back on the record. I'm not

sure we ever left the record. I'll leave that for Karen to figure out based on what I was talking about.

But at any rate, this document that was signed by you on December 2nd, 2020, you did not prepare this document; is that fair?

A. Not the final form, no. But I felt it accurately represented my thoughts on the matter or I would not have signed it.

Q. Okay. When you look at paragraph number 1, can you tell me what the medical records that were forwarded to you by Mr. Lynn's counsel were that you reviewed to prepare this?

A. The medical records from the Charleston, South Carolina Veterans Administration Hospital.

Q. Okay. Do you know how far back they went at the time --

A. They were voluminous. I'm sorry. I cut you off. I apologize.

Q. I was just saying, do you know how far back in time the records were that you were given?

A. I don't recall. But there were several thousand pages of records. I do recall that.

Q. Okay. That's what I would like to

clarify. At some point during the discovery phase, which we are in currently of this case, we provided about 9,000 pages to plaintiff's counsel. I'm wondering did you have that many pages at the time you provided this record or was that different?

A. There were quite a few thousand pages. I don't recall, it's been some time, whether it was exactly 9,000 pages, but it was quite voluminous.

Q. Okay. Can you just summarize the relevant portions that you would have reviewed, just so that I don't ask you questions that go too far back, to get a better understanding of where the Charcot foot issue with Mr. Lynn may have developed that you focused on?

A. I think the key elements for me were sometime in the year 2018 when he was first seeking care for his Charcot's joint.

Q. Okay. That's fair enough. I think for the purposes of this lawsuit, I don't want to go too far beyond maybe that time period. Okay?

A. Yes.

Q. Just so we can hone it in, do you recall that there was an MRI done for Mr. Lynn in that 2018 time period?

A. There was.

Q. And would you agree with me that that MRI was done close in time to when the foot issues began for Mr. Lynn?

A. That's fair.

Q. Okay. I think soon after the MRI, do you understand that Mr. Lynn would have had a referral to an orthopedist who then referred him to a podiatrist?

A. Yes.

Q. And just for purposes of this deposition, do you remember the first podiatrist that Mr. Lynn would have had a consult with?

A. If I recall correctly, it was Dr. Byron.

Q. Yes, sir. Again, just to kind of put a perimeter around these records, is it fair for us to focus on the records from Dr. Byron up until the time of the amputation or for purposes of your Declaration?

A. There was also a second podiatrist, Dr. Ravenel, I believe that's the name, that cared for Mr. Lynn in addition to Dr. Byron or subsequently to Dr. Byron.

Q. Okay. After the Declaration was prepared and signed by -- prepared by someone else

and signed by you on December 2nd of 2020, what additional records have you been given since that time?

A. Two depositions, one by Dr. Ravenel and the other of Dr. Brothers. I believe that would encompass the additional records I have received.

Q. You received transcripts from those depositions already?

A. Yes.

Q. Do you know when you would have received those?

A. In the last two weeks.

Q. Okay. Have you been given any expert reports from the defendant's hired experts?

A. Yes. I should have included that. I apologize. There were three expert reports. One was from a Dr. Fritz, was it, who as I understand is a radiologist; I received a report from a Dr. Del Monte, who I understand to be a podiatrist; and a Dr. Womack, who I understand to be a foot and ankle orthopedic surgeon.

Q. Just to refresh your recollection, how about a vascular surgeon named Dr. Jackson?

A. I don't recall seeing a report from a Dr. Jackson.

Q. Okay. As a result of being provided the two depositions and the three expert witness reports from the defendant's case, have you amended or changed any of your opinions or statements that are included in your Declaration?

A. Somewhat.

Q. Okay. What would be the additions that I have not been privy to by the fact that I have not been given a new declaration?

A. Well, they didn't alter the fundamental basis of my criticism, if that will help you. What I thought was interesting was Dr. Brothers' contention that he examined the leg in the operating room before proceeding with a rather major decision to amputate a man's leg and yet the operative report did not include any description of his doing so, and the pathology report identified no incisions that would have suggested that Dr. Brothers did indeed examine that leg prior to proceeding with the decision to perform an amputation. I thought there was some inconsistency there. Other than that, my opinions have not changed.

Q. Okay. So let's talk about your opinions. Tell me if you come to court whenever

this trial is set for Mr. Lynn, what is or what are your opinions that you are going to testify to in this case?

A. Sure, Mr. Berlinsky. I'll try to summarize them as best I can in a concise manner.

Q. I was going to say, if you want to enumerate them first and go into them or tell me how many there are. Whatever is easiest for you.

A. Not many. I'm very focused on this case.

Q. Okay.

A. Mr. Lynn inarguably had a Charcot's joint deformity of his right foot and ankle, which was severe. He was treated by two podiatric physicians for a Charcot's joint deformity. They both diagnosed him with Charcot's joint. His x-rays and description of his foot in the medical records were consistent with Charcot's joint.

He then in June started to develop increasing redness, pain, and swelling in his right ankle joint. This was addressed by the podiatrists. The key issue arose really January 15th of 2019, as you are well aware. He presented to Dr. Ravenel with continuing increased redness, swelling, and pain in his right ankle joint and had

some loss of appetite and some malaise, general poor feeling.

Dr. Ravenel did not diagnose him with an infection, as you are well aware. He diagnosed him with a Charcot's joint, but due to the degree of swelling and I suppose redness and warmth ordered an ultrasound for a DVT, which was negative. Mr. Lynn was not satisfied, apparently, with that diagnosis and went to the emergency department at the Johnson Charleston VA Hospital. He was diagnosed with an infection in his right foot and ankle, was admitted to the hospital. A CT scan showed the presence of fluid and gas density in his leg, and he was diagnosed with an infection. He was evaluated by Dr. Brothers, and his leg was amputated two days later.

And my criticism is simply stated as follows. There was a diagnosis made of osteomyelitis, which was only based on x-ray interpretation and CT interpretation, as there was never any bone biopsy or pathology done either before the leg was amputated or following amputation by the pathologist. So the diagnosis of osteomyelitis was strictly presumptive and was based on indirect evidence with clinical and x-ray

studies that also would be consistent with Charcot's joint disease and no effort was made to establish that diagnosis.

More importantly to me is this issue of amputating the leg without any type of evaluation. You have to understand to a podiatrist losing a leg is like a physician losing a life. That's what we try to preserve, are legs. And dealing with many amputee patients, I don't think we should take the removal of a man's leg lightly. I think you want to see if there is any chance of salvaging that limb.

This is a patient that had no urgent need for amputation. Mr. Lynn was not febrile. He did not have an elevated white cell count. He was hemodynamically stable. His laboratory studies were unimpressive, and, in fact, were inconsistent with a necrotizing fascial infection. And based on an x-ray that was interpreted as being osteomyelitis without any proof of bone infection and based on a presumption that the gas on the CT scan that was visualized was representative of a necrotizing infection and not simply an infection with a gas-forming organism which would have presented the same way, no effort was made to

verify that diagnosis of a necrotizing infection, and Dr. Brothers proceeded with an amputation. And although he said in his deposition that he did verify this, I think that the absence of describing that in the operative note -- because anyone making a decision to remove a person's leg you would think would have documented I made an incision, I checked, there was advanced terrible destruction, this leg was not salvageable; therefore, I proceeded to make the decision to perform an amputation. Because his leg was not in danger. Even Dr. Brothers' own notes state clearly that Mr. Lynn was hemodynamically stable. There was no urgency to remove that leg to, quote, save his life. So that's sort of my issue.

Number 2 is if this were a necrotizing infection, that does not mandate the need for an amputation. Necrotizing infections call for antibiotic therapy certainly. They call for debridement, incision, and drainage, but just making a diagnosis of necrotizing fascitis does not equal the need for immediate amputation, particularly in a person who is hemodynamically stable.

Number 3 is if the argument is made

that this man's leg was somehow in danger with no fever, no elevated white count, no significant laboratory abnormalities, if that's the argument that this man had necrotizing fascitis -- a diagnosis that Dr. Brothers never entered in the medical record. He said it was an abscess, he said it was osteomyelitis, he said it was possibly cellulitis, but he never used the term, I don't believe, necrotizing fascitis.

But let us say that Dr. Brothers says, well, I didn't write it, but I really thought this man had a life-threatening problem. There was no -- why would he wait 48 hours? Now, the discussion was held that when he entered the hospital, he was, quote, over-anticoagulated because he was on Warfarin since he had had a history of prior deep vein thrombophlebitis, and Mr. Lynn suffered from a congenital clotting disorder that's called factor V Leiden mutation, and he was on Warfarin, which you probably well know is a blood thinner for the fact that he had a history of prior DVT and he had factor V Leiden.

If Mr. Lynn's leg were in danger somehow, even though his leg was so unimpressive that the same day he was admitted Dr. Ravenel saw

him and was not impressed that there were signs or symptoms of infection, but if that were the case, then you would have reversed the Coumadin. You don't have to wait 48 hours. You could have given him plasma. You could have given him it's called four-factor concentrate. It's like a prothrombin concentrate. If the man's leg were in danger, you could have within hours reversed that heparin and taken him to the operating room. So the suggestion that this was an urgent matter but they had to wait somehow 48 hours to wait for the Coumadin to go away and get in range is not consistent with medical fact.

When you have an emergency -- when I've had patients with serious infections or major fractures that required immediate care and they are anticoagulated, the anticoagulants are listed. One of the newer ones, like a Xarelto or a Pradaxa, the newer novel agents, they are a little bit harder to reverse. But Coumadin there are many ways to reverse it almost immediately. You could give a high dose of vitamin K. They gave him 5 milligrams, but you can give him more than that. You could have given it intravenously. And you can give fresh frozen plasma, which within, I don't

know, four or five hours you could take that patient to the operating room. Or you could have given a prothrombic concentrate.

If you treat a patient with a necrotizing infection, the rule you have in surgery is ER to OR. That patient needs to go right to the operating room, not two days later, and if there are confounding factors, such as over-anticoagulation, the patient was 4.1 and he wasn't in range, that's reversible. I've done it. I've had it done for patients of mine in the past. In fact, as I say, I have a patient right now, oddly enough, that I'm waiting for the CT today that we may take to the OR with a necrotizing fascial infection of her leg. And the other thing that's -- so I think she had an infection, don't get me wrong, but I don't think she had necrotizing fascitis. The labs were inconsistent with it. Everyone's behavior was inconsistent with it.

And, again, even if he did -- urgent amputation of that leg was not directly indicated unless you first confirm, yes, that's what he's got, there is irreversible damage, let's proceed with the amputation. That's my criticism, basically. And we have no confirmation at all.

And I have no idea how that VA works. I used to be in a VA hospital myself, the Washington, D.C., VA. I served as assistant director of VA services for the Veterans Administration in Washington, D.C. for podiatry services, and so I have some VA experience, and I've referred Veterans Administration patients here in St. Louis from our VA hospitals to my office for surgery. So I'm not unfamiliar with the VA hospital system, and I don't -- so I don't think they function in a way different from most, well, somewhat different, but generally most medical care. And I have no explanation as to why that leg wasn't examined to establish the reason the leg was amputated. As you well know, there was no verification of any of these diagnoses.

So basically I'm saying I don't argue that Mr. Lynn had an infection superimposed on a Charcot foot. My argument is whether the leg had to be amputated without at least some effort at verifying the pathology, the diagnosis that Dr. Brothers presumably made, although nowhere in the record does he ever say necrotizing fascitis. He uses words like abscess, cellulitis, and misinterpretation of those x-rays as being

osteomyelitis. And if it was osteo, we don't know that because no one ever did anything to verify the diagnosis.

So that's my -- that's really where I'm focused, is the decision to do the amputation, particularly in a man who is stable. This was not a patient who was on death's door. I had a patient, as I said earlier, this year. His foot was gangrene and dead. He was febrile. He had like a 20,000 something white count. He was hemodynamically unstable. Mr. Lynn was far from that. He was far from that. And the patient I have right now in the hospital with a potential necrotizing fascial infection, infectious disease and I are going back and forth right now because she has got an initial negative CT scan but she has got some arguable signs and symptoms consistent with a necrotizing fascial infection. I'm going to see her this evening, and she may have to be an add-on if her CT comes back confirming that, yes, she has got problems, but we are going to open it up and look and confirm that she has a major issue, and we're going to debride her and do an incision and drainage but we are not going to -- well, I can't amputate legs anyway by law, but we are

certainly not going to just pass her off to orthopedics or vascular or general surgery and say, well, there you go, she has got an infection, so take her leg off. I think that's what happened here, quite frankly. I really do.

I just think there should have some verification to say, yes, this is an unsalvageable leg, which it doesn't sound like there was, and so we're going to take the leg off, we don't want to but we have to. That's my criticism.

Q. Well, I think you just broke my record for the amount of time. I have to go back in and ask you a lot of questions about everything that you just testified to. So let's see if I can do this. I'm not sure where to start.

You said that you had one patient currently in the house and one earlier this year that related to a necrotizing soft tissue infection, correct?

A. I had one that was confirmed earlier this year. The patient we're watching now potentially has that. I mean, it's hard to explain. She is growing an alpha streptococcus, which is one of the more common germs that cause this problem, so we're watching her carefully now,

and based on her CT scan which was performed today, this morning, we may or may not take her to the OR.

Q. Well, it was just a yes-or-no question. I'm going to try to go through this as quick as I can. I'm trying to get a gauge on how many times you have had experience with necrotizing fascitis in your patients.

A. A couple times a year. Mostly in the foot. Occasionally in the leg.

Q. Okay.

A. It's not common.

Q. Right. So let's just assume that in South Carolina a podiatrist cannot work above the ankle. Okay? Is necrotizing fascitis something that you've seen in the foot area?

A. Of course. Of course you do.

Q. Okay. And you were saying that this particular patient didn't have a sign of infection. I believe that you even write that in your paragraph number 4. Let's see if that's the right paragraph. It says: No signs or symptoms suggestive of acute infection or sepsis. Is that the reference that you were making to when you were testifying earlier? You said no --

A. I should have inserted the word

pathognomonic, diagnostic of.

Q. You said the white blood cell count wasn't high, no fever, correct?

A. Yes.

Q. And those are things that you are relying on as symptoms for an infection that a doctor would recognize and look at for a differential diagnosis; is that correct?

A. Those are some of them. Those are signs. But, again, when you look at infection, you look at other things. Other laboratory studies, for example.

Q. You mentioned that -- and this is in your dissertation of your opinion or your criticism. I didn't think you called it an opinion. Your criticism. You said that Mr. Lynn had a loss of appetite and some malaise. You testified to that earlier.

A. Yes.

Q. But you didn't extract that from the notes of Dr. Ravenel, did you?

A. No. That was in the hospital records, and the records said that those symptoms had been ongoing for approximately four days, I believe.

Q. You didn't see any record with

Dr. Ravenel on January 15th of 2019 where the patient reported a history that included a loss of appetite or malaise, did you?

A. No.

Q. Did you see any indication when Mr. Lynn was with Dr. Ravenel on January 15th, that morning, where he reported the history of intermittent chills?

A. No.

Q. Did you see where Mr. Lynn told Dr. Ravenel that he had decreased energy?

A. No.

Q. Did you seen where Mr. Lynn told Dr. Ravenel that he had vomit the day before that appointment?

A. No.

Q. Did you see the note where Mr. Lynn reported that he had fatigue for almost four days before the appointment on January the 15th with Dr. Ravenel?

A. No. If this will save you effort, I'm not arguing that Mr. Lynn did not have an infection. I'm arguing that there was evidence that he had a necrotizing fascial infection that required amputation. I'm not arguing that he did

not have an infection.

Q. Do you think that Mr. Lynn's amputation was a result of trying to treat osteomyelitis?

A. It's possible.

Q. Did you see --

A. You mean treating a Charcot that was, in fact, osteo? Is that what you are asking me?

Q. What I'm asking you is do you think that Dr. Brothers performed an amputation on Mr. Lynn to treat osteomyelitis?

A. That was part of his -- yes, because he states in his record that Mr. Lynn had osteomyelitis. Dr. Brothers made that diagnosis.

Q. Okay. Do you think that the osteomyelitis was in the foot region where the Charcot foot disease was?

A. I don't know that there was ever osteomyelitis anywhere. But if it was, it could have been in the foot, it could have been in the ankle, it could have been in the distal tibia and fibula.

Q. Okay. Do you believe that Dr. Brothers amputated the leg of Mr. Lynn to treat the necrotizing fascitis?

A. Yes.

Q. Okay. Do you think that there was an amputation to treat necrotizing fascitis and osteomyelitis? Do you think that was in Dr. Brothers' differential diagnosis, to perform that procedure?

A. Yes.

Q. When you look at your opinion, which is number 7 --

I'm going to read it into the record.

-- it says: It appears that the non-podiatric medical staff of the Charleston South Carolina Veterans Administration Hospital was unfamiliar with Charcot's joint disease, which occurs with frequency in a patient with diabetes, neuropathy, and concurrent pathology such as obesity. Do you see where I read?

A. Yes.

Q. Where does that statement come from that the non-podiatric medical staff at the VA was unfamiliar with Charcot joint disease?

A. The fact that they -- that Dr. Brothers presumed the diagnosis of osteomyelitis based on x-ray and CT evaluation when, in fact, those same x-ray changes may have been representative of Charcot's joint, and that should have been included

in a differential diagnosis. It's a very difficult differentiation to make.

Q. In your opinion, what does it take to qualify as a non-podiatric medical staff member to be familiar with Charcot joint disease?

A. To be familiar?

Q. Right.

A. It would be reflected in your medical records, your decisionmaking, the fact that you recognize there are advanced resorptive or destructive bone changes, and these could be representative of osteomyelitis or they could be representative of Charcot's joint disease, and efforts would be made to try to discriminate the two because the treatment is entirely different.

Q. Your statement says that the non-podiatric medical staff was unfamiliar with Charcot joint disease, and I want to know what does it take in your opinion to be familiar with that?

A. I just answered your question.

Q. Is it based on the number of cases?

A. In part. Obviously it's just your general knowledge of the entity.

Q. Who exactly are you referring to in that statement?

A. Dr. Brothers.
Q. Anyone else?
A. No.
Q. How do you know what experience Dr. Brothers has with Charcot joint disease?
A. He described it in his deposition.
Q. Based on his description, you don't believe he is familiar with Charcot joint?
A. I think he has got some familiarity.
Q. And what is he lacking?
A. Experience. It's not his specialty.
Q. How many cases would you say a doctor would have to see of Charcot joint to be familiar with Charcot joint?
A. It would be strictly conjecture on my part.
Q. Well, I don't remember seeing -- I don't remember the number that Dr. Brothers stated, but I thought it was 10 to 15 cases a year. Is that not enough? You can correct me if I'm wrong.
A. I would think that would be adequate experience, if he understood what it was he was seeing.
Q. It's your testimony, if I understand it, that Dr. Brothers specifically is a

non-podiatric medical staff member and he is unfamiliar with Charcot joint disease. Is that my understanding of your testimony?

A. Yes.

Q. Okay. Have you seen any written statements or had any conversations with anyone else about Dr. Brothers' experience with or without a lacking in Charcot foot disease?

A. No.

Q. Looking at your Declaration in paragraphs number 5 and number 8, there is a sentence that's very similar in both of them. So I'm going to give you a chance to read them both. If you would refresh your memory with paragraphs 5 and 8 as it relates to the abscess that's present.

A. Okay. I've looked at it.

Q. It says -- in paragraph number 5, it says: If, in fact, an abscess had been present, this could have been properly treated by incision and drainage and not urgent amputation of the right leg. Do you see that?

A. Yes.

Q. And then in paragraph 8, it says: If, in fact, Mr. Lynn suffered from an abscess, this could have been treated by incision and drainage.

Do you see that?

A. Yes.

Q. Did you see where Dr. Brothers had a medical note on January the 16th that he was considering incision and drainage and possible debridement of Mr. Lynn?

A. Yes.

Q. Did he, in fact, consider incision and drainage?

A. Well, he didn't do it. So he may have thought about it, but it was not done. That's my major criticism. There is nothing that would have been lost by saying before I make the decision to remove his leg, I'm going to open this up and look and confirm my impression. That was not done.

Q. Is it your opinion that once you open the leg up you can close it back and then talk to the patient or is that done simultaneous in the procedure?

A. No. He would have said: Mr. Lynn, I'm going to open this leg. I'm going to examine it and see if we have something that we can save and effectively cure over time or possibly cure over time or if it's apparent that there is too much damage, there is too much destruction. If there is

too much necrosis, we cannot salvage this leg, then we are going to go ahead and remove it. I think that would have been the appropriate thing to do.

I mean, that's the focus of my criticism. Everything that was done here was indirect evidence or presumption, when it was possible that that was not the diagnosis, and because the leg was never examined for some reason we'll never know whether there was or was not an unsalvageable situation.

Q. That's your opinion, that it was not examined, correct?

A. Well, I know it wasn't examined because you would have put it in the operative note. And, number 2, the pathologist has a description of the skin, and there is no description of any additional incisions other than the one made at the level of the amputation.

Q. I understand. I understand what you are saying about the pathology. I'm talking about Dr. Brothers. If he has a different recollection as to looking at the site of the infection to determine whether or not it was salvageable and he made a decision intraoperatively that it was not salvageable, would that have been the correct thing

for him to do?

A. Yes.

Q. Okay. And by the correct thing, that means if it's not salvageable then you amputate, correct?

A. If it's not salvageable, correct. Understanding, again, that not every case of necrotizing fascitis requires amputation.

Q. I want to ask you about that. You talk about the abscess in general. Which location are we talking about here?

A. In the leg. The distal leg.

Q. So is your description of the abscess the gaseous tissue that was described in the leg area and not in the foot?

A. I don't know where the infection extended from because, as you know, there was no open wound and there is not necessarily -- I mean, the gas can travel. So there is not always a direct correlation between the gas visualized and the exact level of the infection, but it was the anterior lateral aspect of the right leg.

Q. When you look at paragraph number 32, you have the boldface font referring to the left foot -- left calf, ankle, and foot. Do you see

that in paragraph 32?

A. Yes.

Q. Why is that in boldface?

A. I did not do that. So I don't know why that was put the way it was. As you know, there was some confusion as to x-rays and so forth, but no, I did not bold that.

Q. Did you yourself ever look at the x-rays or the CT scans or the MRI or have you only looked at the impressions that were prepared by radiology?

A. I was sent some of the images. I don't recall how many. There were quite a few taken in the last two years, but I did look at the -- some of the radiographs and I believe the CT.

Q. Are you yourself trained to identify necrotizing fascitis?

A. To a point. I don't pretend to have the expertise of a radiologist, but I over read my own CTs.

Q. Do you disagree with Dr. Fritz's report that he identified the necrotizing fascitis that was mentioned on the CT scan?

A. I don't recall if he -- well, no, I don't disagree. I agree that the changes he

so-called described in his little term paper were present.

Q. Did you make a note when you were reviewing the records in this case why vascular surgery was consulted by Dr. Glover from the emergency department?

A. No.

Q. Are you aware, does it matter to you, if Dr. Glover contacted vascular surgery to look at a necrotizing fascitis that he was suspicious of?

A. No.

Q. Would that have been the proper decision made by an emergency room physician to consult with vascular surgery in that situation?

A. They can consult with vascular. They can consult with general surgery. They can consult with orthopedics. I don't know what the particular regimen is that's followed at the Charleston VA Hospital.

Q. Okay. When the consult was made to vascular surgery, do you think that the knowledge and experience of Dr. Brothers required him to follow up with the request for service?

A. No. I would think if he -- if that's the -- if that's the referral pattern that's

typically followed, then of course it's appropriate.

Q. I want to go back. You had sort of deflected an answer to my earlier questions, and I wanted to make sure it's on the record. We were talking about intermittent chills, decreased energy, decreased appetite, fatigue, vomiting and nausea earlier that are things that are mentioned in Mr. Lynn's emergency room medical records, correct?

A. Yes.

Q. Are those considered symptoms of an infection?

A. It can be.

Q. Okay. And do you know if a blood glucose lab finding of greater than 400 can be considered a finding of, symptomatic of, an infection?

A. It can be.

Q. Okay. You don't disagree that the record clearly indicates that with those findings that it's a possibility that he had this ongoing infection and had those symptoms, correct?

A. That's correct. Again, to be clear, I'm not arguing there was an infection. I mean,

take, for example, if I were an attorney, which obviously I am not, but if I were an attorney, I would -- and I wanted to paint this in an opposite direction, if I were the plaintiff attorney, I would say, well, Dr. Jacobs, he also had redness, swelling, and pain ongoing since June, are those not also signs and symptoms of an infection? I would say, yeah, they could be. So signs and symptoms are -- these things are not pathognomonic.

Mr. Lynn had a terrible history of poor diabetes control, for example. It wouldn't be shocking to find a significantly elevated glucose in this gentleman because I believe the last hemoglobin A1C I saw was something like 12.6, or something like that. So I'm not arguing with you. I'm just letting you know to be fair these things are not pathognomonic.

Yes, everything you mentioned are absolutely consistent with a possible infection. I would never suggest otherwise.

Q. Going back to the first MRI of Mr. Lynn that is relevant to this case, being in July of 2018 and following current with x-rays that were done in August of 2018 and October of 2018 right on up through the January 15th time period, did you

see any imaging or studies that had any gas bubble infections or gas bubble tissue?

A. No.

Q. Okay. And you mentioned that Mr. Lynn had redness and swelling and pain associated with his leg that he was being seen for by podiatry on January the 15th, correct?

A. Yes.

Q. Are those proper indicators for Dr. Ravenel to have considered getting a DVT Dopplar study done since Dr. Ravenel had put him on non-weightbearing for such an extended period of time prior to that date?

A. Of course.

Q. Okay. So you don't have a problem with Dr. Ravenel ordering a DVT Dopplar, do you?

A. Of course not.

Q. Okay. What in your understanding of necrotizing fascitis would have occurred if Dr. Brothers had not amputated at the time when he did? You are suggesting that he would have tried an incision and a drainage and possibly a round of antibiotics, correct?

A. Well, incision, drainage, and a debridement. You have to go about cleaning out all

the dead tissue and infected tissue. You don't just make an incision -- well, if we were lucky, it would have been an abscess and you could basically do an incision and drainage. What I'm saying again is even if it were a necrotizing fascial infection, that doesn't mean the patient cannot be treated by an aggressive debridement with antibiotics.

So incision and drainage alone may not be sufficient. And I just want to remind you, I'm sure you know this, that just because you find air on a CT scan doesn't make a diagnosis of necrotizing infection because there are many germs that are gas producers. So you can have an infection with a bacteria that produces gas, and there are many such organisms, but, again, that does not mandate the need for amputation. Finding air density on an x-ray or CT scan does not equal a diagnosis of gas gangrene or a necrotizing fascial infection. That's all I'm saying.

The leg should have been opened first, the diagnosis confirmed or not confirmed, and then if the diagnosis were confirmed, you say, I'm sorry about this but the leg has to go. And that's my whole -- that's the basis of my criticism.

Q. Did you disagree with the treatment of

the vancomycin and other antibiotics that the hospital had him on beginning on the 15th?

A. Of course not.

Q. Okay. Do you think that he was on those antibiotics long enough for the doctors to get an understanding as to whether or not there was any improvements?

A. Well, I can't answer that question because you are talking about an individual that basically had benign laboratory findings, did not have overwhelming clinical findings. So I'm not sure what there was to improve. Dr. Brothers' own note said that he was stable on the 16th, the day before the amputation, and that he was thinking about doing an incision or drainage and maybe amputating the foot. He wasn't even talking about the leg. So I'm not sure what there was to improve, I guess is what I'm saying.

For example, I have half a dozen patients in the hospital right now with infections of the leg and/or foot, mostly leg, actually, right now, and they are admitted with an elevated white count or elevated markers for inflammation. And we give antibiotics, and we look for those markers to come down. We look for the white cell count to

come down, their fever to come down, their sedimentation rate to come down, other things, but there you have a comparator. But when a patient starts with normal laboratory findings, I'm not sure how you judge improvement when they are all within normal range. Did I explain that okay?

Q. Yes. Your report doesn't mention necrotizing fascitis at all, does it?

A. No.

Q. Did your notes to the attorney before he prepared this Declaration mention necrotizing fascitis?

A. I don't think so.

Q. When was that first put on your spectrum of being relevant in this case?

A. I don't recall.

Q. Was it after you received the expert reports for the defendant's hired and retained experts? Was it after you got those reports?

A. No. I think it was before I saw -- Dr. Fritz was really the one that defined that the most. I think the other two expert reports that I saw sort of said, well, it could have been.

Q. You didn't see any record in the -- any notes in the medical record of Mr. Lynn that

mentioned necrotizing fascitis?

A. There was one reference somewhere, and that was it.

Q. What was that on?

A. I don't recall. It might have been in the radiology report, but I'm not certain where I saw it, but I only saw the term used one time. And it was never used by Dr. Brothers. But I assume, maybe I'm incorrect, which to me makes the criticism stronger, actually, that that was the basis on which Dr. Brothers went ahead and did the amputation. Because if it was just an abscess, then clearly an effort at incision and drainage would have been indicated.

I was trying to think -- he didn't have any gangrene. His vascular status was adequate. Dr. Brothers described him as having strong Dopplar-able pulses. So we didn't have an ischemic issue. We didn't have a compartment symptom. And so I looked at this and said, well, what would motivate one to do an urgent amputation of a leg for an infection, and necrotizing fascitis is the thing that comes to mind immediately because I couldn't think of any other infection that you would immediately amputate a leg for without at

least looking and confirming the diagnosis.

Q. Would the end result be -- if there was no amputation and it was a necrotizing fascitis what would have happened?

A. If there were no amputation? If it was truly necrotizing fascitis, then I would assume at some point Mr. Lynn would have become quite ill. He would have started to develop fevers, have an elevated white count. There is all sorts of manifestations. He could have gone into shock, could have gotten hypotensive. I mean, there is all sorts of manifestations of sepsis, but he would have gotten septic.

Q. Do you rate manifestations in groups of seriousness? Like, is white blood cell raising or fever more important than loss of appetite, vomiting, things of that nature that he already had exhibited?

A. No. They were all part of your evaluation of a patient. I don't think one necessarily takes priority over the other. The ultimate would have been to incise the area and examine it and see what was happening. That's ultimately what needed to be done.

Q. And what if Dr. Brothers had incised it

and drained it and then the infection remained and would just continue to manifest, what would the next step be?

A. It depends. But amputation would certainly have been a consideration.

Q. Okay.

A. I had a woman far less serious, we amputated a toe, and it was salvageable, but I told her because of the chronicity of this problem you would always have sort of a swollen funky looking toe. It might be bothersome in shoes, but it's treatable. And she said I just want the toe off and I want to be done with it. So it's a far less of a serious issue, but -- so you really don't know what the outcomes would be in the long term. People survive terrible things and other people seem to succumb to relatively minor -- or seemingly minor issues.

Q. Are there other physicians such as Dr. Brothers that would be vascular surgeons that would have opened up the leg, seen the same thing that Dr. Brothers saw, and amputated?

A. I have no idea what other people would have done. I could only speak to the records I had in this case to look at.

Q. Do you know how fast necrotizing fascitis moves?

A. Well, that's another issue. You are saying, well, he had all these signs for four days.

Q. I asked you -- before you go off, I just want to ask you a direct question. Do you know the rate at which necrotizing fascitis moves from muscle to muscle?

A. It's very fast.

Q. Okay. And give me an example of what very fast is in --

A. It could be 24 to 48 hours. And it's a very fulminant infection typically. And you are saying now that this man had symptoms of that infection for at least four days prior to admission, so he had plenty of time to get plenty sick if this were, in fact, a necrotizing fascial infection.

Q. Could it have occurred from the timeframe of seeing Dr. Ravenel to going to the emergency department?

A. I think he could have gotten worse in a couple of hours, of course. Some cases do get -- do advance that rapidly. That's why I told you earlier it's ER to OR.

Q. Dr. Jacobs, I'm going to ask if we can go off the record for a few minutes. I'm just going to look over a couple of things and try to get back as soon as I can on this. Okay?

A. Sure.

Q. Stretch or take a comfort break.

(A recess transpired.)

BY MR. BERLINSKY:

Q. I'm just going to try to close out the deposition, Dr. Jacobs. If I understand your testimony, then I'm just going to get a couple quick summaries.

I think that you testified that the blood glucose, the intermittent chills, the decreased energy, the decreased appetite, the fatigue, and the vomit, those are signs and symptoms of an infection?

A. Can be.

Q. Okay. And where you say in paragraph 4 that there were no signs and symptoms of infection -- symptoms of infection, we just went through that, that's not really as accurate based on what we just talked about, correct?

A. Correct.

Q. And as far as the decision of the

vascular surgeon to amputate the leg for necrotizing fascitis, that in and of itself is not a deviation in the standard of care of vascular surgery. Are you able to testify on that opinion?

A. Obviously you know as well as I do I cannot testify to vascular surgery standards of care.

Q. Okay. It sounds to me like you didn't see any evidence in the record that cleared up a presumptive finding of necrotizing fascitis and you think that was a requirement, correct?

A. No. What I'm suggesting is even if the diagnosis were that of necrotizing fascitis that there is still the opportunity to salvage a limb. Or other part of the body. I mean, it's not a disease you just get on the leg or the foot. There is the opportunity for salvation of that -- or preservation of that limb with an aggressive debridement, usually multiple debridements are required, but you can salvage the leg. So I'm saying even if there was a true diagnosis of necrotizing fascitis, because all we have is indirect presumptive evidence, that still does not mandate amputation of the limb, that you can salvage limbs with necrotizing fascitis. It's a

lot of work and -- there is no doubt about it, but they are salvageable in some cases. Not all, but some.

Q. Other than visualizing a finding during the surgery, how would you suggest confirmation of necrotizing fascitis?

A. You can't. Everything else is presumptive.

Q. Okay. I just wanted to make sure.

A. It's indirect evidence. You can say x-rays look like it, labs look like it, patient kind of looks like it, but, again when you are making the major decision such as removing a leg from a human being, it's nice to sort of at least take the time to look and say, yes, unfortunately they have what we thought they had and this leg needs to be removed.

Q. Yeah. I think you would agree with me that sometimes a necrotizing fascitis can be embedded so deep in tissue that there is no vascular component that even a blood culture would come back confirming. Is that not right?

A. I suppose that's theoretically possible. Dr. Fritz had somebody go and dig up a bunch of articles that said, well, you can have

necrotizing fascitis without a fever, without a leucocytosis, but these are -- I mean, anybody who treats these things knows this would be extremely atypical. These patients are typically pretty sick, especially if they have been having symptoms four days preceding their admission to the hospital. By that time, these infections are pretty aggressive and pretty fulminate, and you should have seen something.

Q. That's the second time you made a comment on Dr. Fritz's report. I take that to mean that I should ask you a question. Do you have any issues or take a position about Dr. Fritz or any of the other expert opinions that you've read from the defendant?

A. No.

Q. Do you have any reason to disagree with any of their findings, that the vascular surgeon was within the standard of care of amputating the leg to prevent the necrotizing fascitis from spreading?

A. Well, I don't think Dr. Fritz is in any position to comment on the standard of care for a vascular surgeon any more than I am. He is a radiologist. So, no, I just found it interesting

that he took such a strong position in his report regarding the essence of his findings that this was consistent with a necrotizing fascial infection. To me it actually argued more strongly that some confirmation should have been made because, here again, the mere fact that you have necrotizing fascitis does not mandate amputation. It just doesn't. You can salvage some of these limbs, and Mr. Lynn was denied that opportunity.

Q. I'm going to take a chance to read your report. I don't have any other questions for you at this time, and if we need to go back on the record, then I'll set that up with the attorneys. It's highly unlikely, but I just want to leave that out there as a potential.

MR. TINKLER: Thank you. I don't have any questions, Dr. Jacobs.

(Off-the-record conference.)

(The witness, after having been advised of his right to read and sign this transcript, waives that right.)

(The deposition concluded at 3:35 p.m.)

UNITED STATES DISTRICT COURT
DISTRICT OF SOUTH CAROLINA

NOTICE REGARDING BENCH TRIAL

To provide for an orderly and expeditious disposition of the cases on the trial calendar, the following provisions must be complied with:

1. **Fed.R.Civ.P. 26(a)(3) PRETRIAL DISCLOSURES** shall be filed and exchanged between the parties **thirty (30) days prior to the date set for trial**. Within fourteen (14) days thereafter, parties shall file and exchange Fed. R. Civ. P. 26(a)(3) objections, any objections to use of a deposition designated by another party and any deposition counter-designations under Fed. R. Civ. P. 32(a)(6)
2. **MOTIONS IN LIMINE** must be filed no later than **30 days prior to the date set for trial**. Written responses are due seven (7) days thereafter. ***No motions in limine shall be filed until counsel have consulted and attempted to resolve the matter as required by Local Civil Rule 7.02.***
3. **TRIAL BRIEFS** are due at least **seven (7) days prior to trial** and are to be e-mailed in WordPerfect or MS WORD format to chambers at Dawson_Ecf@scd.uscourts.gov in accordance with Rule 26.05 of the Local Rules.
4. **EXHIBITS**. Attorneys for each party shall meet at least **seven (7) days prior to trial** for the purpose of exchanging and marking all exhibits to be used at trial, and, where possible, agree on the admissibility of all trial exhibits. In the event there is an objection to any exhibit, the attorneys must notify the court of such objection ***at least one day prior to trial***. Otherwise, such objection will be deemed waived. The exhibit list shall be furnished by each side to the Courtroom Clerk on the day of trial. All exhibits listed shall be deemed admitted for all purposes unless the court denies admission based on objections submitted to the court as set out above.
5. **PROPOSED FINDINGS AND CONCLUSIONS OF LAW**. The parties are to submit proposed findings and conclusions of law via email to chambers at Dawson_Ecf@scd.uscourts.gov no later than five (5) business days prior to trial.

THE COURT MAY NOT CONSIDER ANY EXHIBITS FOR TRIAL SUBMITTED AFTER THE ABOVE REFERENCED DATES.

COUNSEL ARE REQUIRED TO USE THE ELECTRONIC COURTROOM PRESENTATION SYSTEM IN TRIAL. If your case is going to trial and you did not participate in electronic courtroom training when it was offered, it is **YOUR** responsibility to contact the court clerk for information regarding use of the electronic courtroom **PRIOR TO TRIAL**. It is not possible to be trained the morning of trial.

In accordance with the provisions of 28 U.S.C. 636(c), you are hereby notified that the United States Magistrate Judges of the District Court, in addition to their other duties, may, upon consent of all parties in a civil case, and with the approval of the District Judge, conduct any or all proceedings, including a Jury or Non-Jury trial, and order the entry of a final judgment.

BY DIRECTION OF THE COURT
s/Rob Weber
ROBIN BLUME, CLERK

UNITED STATES DISTRICT COURT
DISTRICT OF SOUTH CAROLINA

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BY DIRECTION OF THE COURT
s/Rob Weber
ROBIN BLUME, CLERK

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
CHARLESTON DIVISION

Keith Lynn and Jennifer Lynn, Plaintiffs, v. United States of America, Defendant.	**CA: 2:20-cv-04277-JD** **ORDER**

In this Federal Tort Claims Act ("FTCA") case, Defendant United States of America ("Defendant") has filed a Motion *In Limine* (DE 34) seeking to limit Plaintiffs Keith Lynn ("Mr. Lynn") and Jennifer Lynn's ("Mrs. Lynn") (collectively "Plaintiffs") expert Dr. Allen Mark Jacobs ("Dr. Jacobs") testimony under Rule 702, Fed. R. Evid., and Daubert "to his field of expertise, and only regarding the events forming the basis of the SF-95." (DE 34 p. 6); see also Daubert v. Merrell Dow Pharm., Inc., 509 U.S. 579, 592 (1993). Plaintiffs have submitted a Memorandum in Opposition to Defendant's Motion *In Limine*. (DE 39.) After reviewing the motion and memoranda, the Court denies Defendant's Motion *In Limine* (DE 34) for the reasons stated herein.

BACKGROUND

Mr. Lynn is a fifty-one-year-old former member of the United States Navy who was honorably discharged in June 1997 after approximately seven and one-half years of service. Mr. Lynn is eligible to receive medical care from the Department of Veterans Affairs ("VA") as a benefit of his naval service. (DE 1, ¶ 1.) According to Plaintiffs, on or about January 15, 2019, Mr. Lynn presented at the VA's Charleston facility with pain and swelling of his right leg. (Id. at ¶ 8.) At that time, Keith had a history of pain and swelling of his leg and was being monitored by podiatrists at the VA for a diagnosis of Charcot's joint disease. (Id.) After presentation on January

15, 2019, the non-podiatry staff at the VA diagnosed osteomyelitis and performed a below the knee amputation of Keith's right leg.[1] (Id. at ¶ 9.) Plaintiffs allege that they thought a misdiagnosis had occurred leading to the amputation, so they gave notice of their claim to the VA on October 10, 2019, by submitting Standard Form 95s ("SF-95"). (DE 34, p. 3.) Further, Plaintiffs' Complaint alleges "[t]hat there was insufficient evidence to support a diagnosis of osteomyelitis and the amputation performed on January 17, 2019, was unnecessary." (DE 1, ¶ 10.) On the other hand, Defendant contends Plaintiffs' SF-95 only indicated that the basis of Plaintiffs' claim is that the government failed to diagnose osteomyelitis resulting in the above knee amputation. (DE 34, 34, p. 4.) Thereafter, on December 9, 2020, Plaintiffs filed this action claiming medical negligence under the FTCA, and they retained Dr. Jacobs to provide his opinion. (DE 1.) Dr. Jacobs, a podiatrist with over 40 years of experience treating patients who suffer from diabetes, neuropathy and Charcot joint disease, performed a review of Mr. Lynn's medical records from the VA and opined,

> 'with a reasonable degree of medical certainty' that '[t]he medical records indicate clinical signs, symptoms, and radiographic and imaging changes consistent with Charcot's joint disease' and that 'there was never any direct evidence demonstrating osteomyelitis, and the urgent removal of Mr. Lynn's right leg was neither indicated nor necessary and was a departure from the applicable standard of care.'

(DE 1-1, ¶¶ 11, 36.) However, during his deposition, Dr. Jacobs was examined on the decision of the vascular surgeon to amputate the leg for necrotizing fascitis, and whether that was a deviation in the standard of care of vascular surgery. (DE 39-2, p. 15-16, 53:25-54:4.) Dr. Jacobs testified that "[o]bviously you know as well as I do I cannot testify to vascular surgery standards of care." (DE 39-2, p. 16, 54:5.) Given the information on the SF-95 and Dr. Jacobs's testimony, Defendant

[1] According to the Defendant, Mr. Lynn's medical records indicate that he had the below knee amputation on January 17, 2019, and then in June 2019, he had a revision surgery due to heterotopic calcification of the amputated bone, which led to an above the knee revision surgery.

seeks to limit Dr. Jacobs's expert testimony "to the field of podiatry regarding to [sic] the failure to diagnose osteomyelitis resulting in the below knee amputation that occurred on January 17, 2019, as that is the basis and date of the injury identified in the claim presented to the agency under the Federal Tort Claims Act." (DE 34, p. 3.)

LEGAL STANDARD

Motion in Limine

"Questions of trial management are quintessentially the province of the district courts." United States v. Smith, 452 F.3d 323, 332 (4th Cir. 2006). "The purpose of a motion *in limine* is to allow a court to rule on evidentiary issues in advance of trial in order to avoid delay, ensure an even-handed and expeditious trial, and focus the issues the jury will consider." United States v. Verges, No. 1:13-cr-222-JCC, 2014 U.S. Dist. LEXIS 17969, 2014 WL 559573, at *2 (E.D. Va. Feb. 12, 2014). When ruling upon a motion *in limine*, a federal district court exercises "wide discretion." United States v. Aramony, 88 F.3d 1369, 1377 (4th Cir. 1996) (quoting United States v. Heyward, 729 F.2d 297, 301 n. 2 (4th Cir. 1984)). However, a motion *in limine* "should be granted only when the evidence is clearly inadmissible on all potential grounds." Verges, 2014 U.S. Dist. LEXIS 17969, 2014 WL 559573, at *3; see also Fulton v. Nisbet, C/A No. 2:15-4355-RMG, 2018 U.S. Dist. LEXIS 13342, 2018 WL 565265, at *1 (D.S.C. Jan. 25, 2018).

Expert Witness/Fed. R. Evid. 702

District courts "must ensure that any and all scientific testimony or evidence admitted is not only relevant, but reliable." Daubert, 509 U.S. at 589. Rule 702 was amended in response to Daubert and its progeny and now provides:

> A witness who is qualified as an expert by knowledge, skill, experience, training, or education may testify in the form of an opinion or otherwise if: (a) the expert's scientific, technical, or other specialized knowledge will help the trier of fact to understand the evidence or to determine a fact in issue; (b) the testimony is based

> on sufficient facts or data; (c) the testimony is the product of reliable principles and methods; and (d) the expert has reliably applied the principles and methods to the facts of the case.

Fed. R. Evid. 702. The proponent of an expert witness's testimony bears the burden of proving that such testimony meets the requirements of Rule 702 by a preponderance of evidence. See Daubert, 509 U.S. at 592 n. 10. District courts serve as gatekeepers for expert testimony and carry a "special obligation" to ensure that expert testimony is reliable and relevant. Kumho Tire Co. v. Carmichael, 526 U.S. 137, 147 (1999). The Court must, therefore, ensure that an expert's testimony is based on "scientific knowledge," and "will assist the trier of fact to understand or determine a fact in issue." Daubert, 509 U.S. at 592. The first inquiry asks, "whether the reasoning or methodology underlying the testimony is scientifically valid." Id. at 592-93. District Courts are guided by several factors in determining the reliability of a particular scientific theory or technique: whether it (1) can be and has been tested; (2) has been subjected to peer review and publication; (3) has a known or potential rate of error; and (4) has attained general acceptance in the pertinent scientific community. See id. at 593-94. These factors are not exclusive; what factors are relevant to the analysis "depend[] upon the particular circumstances of the particular case at issue." Kumho Tire, 526 U.S. at 150. In conducting the reliability inquiry, the focus "must be solely on principles and methodology, not on the conclusions that they generate." Daubert, 509 U.S. at 595.

The second inquiry "goes primarily to relevance." Id. at 591. Relevance is determined by ascertaining whether the testimony is sufficiently tied to the facts of the case such that it will aid the jury in resolving a factual dispute. Id. at 593. "A review of the caselaw after Daubert shows that the rejection of expert testimony is the exception rather than the rule." Fed. R. Evid. 702, Advisory Committee's Note to 2000 Amendments. "Daubert did not work a 'seachange over federal evidence law,' and 'the trial court's role as gatekeeper is not intended to serve as a

replacement for the adversary system.'" Id. (quoting United States v. 14.38 Acres of Land, More or Less Situated in Leflore Cnty., State of Miss., 80 F.3d 1074, 1078 (5th Cir. 1996)).

DISCUSSION

Defendant contends if Dr. Jacobs is qualified to offer expert testimony, his testimony should be limited to his field of expertise and only regarding the events forming the basis of the SF-95. (DE 34, p. 6.) Putting aside whether Dr. Jacobs meets the requirements of Rule 702, Fed. R. Evid., Defendant's attempt to limit his testimony to allegations in Plaintiffs' SF-95 filing, rather than Plaintiffs' Complaint is misplaced in a motion *in limine*. Defendant does not identify any proffered testimony that it claims to be inadmissible. Instead, Defendant challenges whether Plaintiffs may advance a theory of liability raised in its Complaint that allegedly differs in form (but not necessarily in substance) from the theory advanced in Plaintiffs' SF-95 notice. "The purpose of a motion *in limine* is to allow a court to rule on evidentiary issues in advance of trial in order to avoid delay, ensure an even-handed and expeditious trial, and focus the issues the jury will consider." Verges, 2014 U.S. Dist. LEXIS 17969, 2014 WL 559573, at *2.

On its face, Defendant does not raise an evidentiary issue, rather the gravamen of Defendant's motion targets the efficacy of Plaintiffs' complaint which is jurisdictional. See Drew v. United States, 217 F.3d 193, 196 (4th Cir.), reh'g en banc granted, opinion vacated (Sept. 8, 2000), on reh'g en banc sub nom. Drew ex rel. Drew v. United States, 231 F.3d 927 (4th Cir. 2000) ("The FTCA prohibits the filing of a civil action against the Government unless the underlying claim is 'first presented' to the appropriate federal agency and subsequently denied. (Citation omitted). Where such a claim is not first presented to the appropriate agency, the district court must, pursuant to Fed. R. Civ. P. 12(b)(1), dismiss the action for want of subject matter jurisdiction."); see also Kokotis v. United States Postal Serv., 223 F.3d 275, 278 (4th Cir.2000)

(identifying the filing of an administrative claim as a "jurisdictional prerequisite to filing suit under the FTCA"). The Fourth Circuit in Drew has "repudiate[d] the notion that the validity of a judicial complaint under the FTCA depends on it having been *cloned* from its predecessor, the administrative claim." Drew v. United States, 217 F.3d at 197 (*emphasis added*). To that end, Plaintiffs contend

> the predicate of the medical negligence claim involved an amputation on January 17, 2019, resulting from an incorrect diagnosis related to Mr. Lynn's treatment by the identified VA employees. The United States was on notice of the 'relevant facts' and witnesses, was in possession of Mr. Lynn's medical records, and could evaluate 'the chain of events leading to the complained-of injury.'

(DE 39, p. 5.) Defendant did not file a reply to Plaintiffs' response regarding the sufficiency of the Defendant's written notice, which provided the basis to investigate Plaintiffs' claim. "The notice must be 'sufficient to cause the agency to investigate' the incident in order to determine its exposure to liability." Degenhard v. United States, No. 5:13-CV-685-BR, 2015 WL 632211, at *1 (E.D.N.C. Feb. 13, 2015) (quoting Ahmed v. United States, 30 F.3d 514, 516 (4th Cir. 1994). Nevertheless, a claimant need not give the government notice of "every possible theory of recovery." Id. at 1. Rather a claimant must allege a sufficient factual predicate for the government to investigate the underlying conduct "to reasonably assess the extent of its liability vis-a-vis the complaint that was subsequently filed." Drew v. United States, 217 F.3d at 198. Accordingly, the SF-95 presented the agency with sufficient facts to put it on notice of the medical incident underlying Plaintiffs' claim; and, therefore, since the jurisdictional administrative exhaustion requirement of the FTCA relevant to the theories contained in the Complaint are satisfied, testimony regarding the same is appropriate.

Next, Defendant contends if Dr. Jacobs testifies as an expert at trial his testimony should be limited to the field of podiatry and not vascular surgery standards of care. Although Plaintiffs concede Dr. Jacobs is not being offered in the field of vascular surgery, and Dr. Jacobs agrees he

"cannot testify to vascular surgery standards of care[,]" nevertheless, Plaintiffs argue his qualifications in podiatry allows him to testify concerning the unnecessary amputation. (DE 39, pp. 7-8.) To that end, Plaintiffs offer Dr. Jacobs's opinion to show "that the medical evidence supports Mr. Lynn's diagnosis of Charcot joint disease and that the VA's providers departed from the standard of care in urgently removing Mr. Lynn's right leg when 'there was never any direct evidence demonstrating osteomyelitis.'" (DE 6, p.10, quoting DE 1-1, ¶ 36.) The proponent of an expert witness's testimony bears the burden of proving that such testimony meets the requirements of Rule 702 by a preponderance of evidence. See Daubert, 509 U.S. at 592 n. 10. Here, Mr. Lynn's case involved multiple different specialties, including podiatry, radiology, emergency medicine, and surgery, but the alleged condition that Mr. Lynn was suffering from–Charcot joint disease—is managed routinely by podiatrists.

Federal Rule of Evidence 702 requires an expert to be qualified "by knowledge, skill, experience, training, or education." Fed. R. Evid. 702. "[A] witness'[s] qualifications to render an expert opinion are [] liberally judged by Rule 702. Inasmuch as the rule uses the disjunctive, a person may qualify to render expert testimony in any one of the five ways listed: knowledge, skill, experience, training, or education." Kopf v. Skyrm, 993 F.2d 374, 377 (4th Cir. 1993). "Accordingly, a challenge based on lack of qualifications alone must demonstrate that 'the purported expert [has] neither satisfactory knowledge, skill, experience, training nor education on the issue for which the opinion is proffered.'" In re Pella Corp. Architect & Designer Series Windows Mktg., Sales Practices & Prods. Liab. Litig., 214 F. Supp. 3d 478, 496 (D.S.C. 2016) (quoting Thomas J. Kline, Inc. v. Lorillard, Inc., 878 F.2d 791, 799 (4th Cir. 1989)). "If, again in the disjunctive, the proposed testimony will recount or employ 'scientific, technical, or other specialized knowledge,' it is a proper subject." Kopf, 993 F.2d at 377. Defendant does not

challenge Dr. Jacobs's more than 40 years of experience as a podiatrist and there is nothing in the record to suggest the conditions presented by Mr. Lynn are not treated by a podiatrist. While the Court notes that "an expert witness may not offer an opinion where the subject matter goes beyond the witness's area of expertise[,]" the record is devoid of these impediments. In re Pella Corp. Architect & Designer Series Windows Mktg., Sales Practices & Prods. Liab. Litig., 214 F. Supp. 3d at 496. Given the record before the Court at this time, the Court finds that Dr. Jacobs has satisfactory knowledge, skill, experience, training, or education on the issue for which the opinion is proffered; and therefore, denies Defendant's Motion *In Limine* to the extent it seeks to limit or exclude Dr. Jacobs's proffered testimony based on his qualifications.

CONCLUSION

For the foregoing reasons, Defendant's Motion *In Limine* (DE 34) is denied as provided herein.

IT IS SO ORDERED.

August 15, 2022
Florence, South Carolina

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
CHARLESTON DIVISION

Keith Lynn and Jennifer Lynn Plaintiffs, vs. United States of America, Defendant.	Case No.: 2:20-CV-04277-JD **ORDER GRANTING CONTINUANCE**

Before the Court is Plaintiffs Keith Lynn and Jennifer Lynn's ("Plaintiffs') Emergency Consent Motion for a Trial Continuance (DE 54) requesting that the trial scheduled for Monday, November 14, 2022, through Friday, November 18, 2022, be continued due to the illness of Plaintiffs' lead counsel. The motion (DE 54) is **granted**. The parties are directed to meet and confer regarding any conflicts for possible trial dates of December 5, 2022 – December 8, 2022, January 9, 2023 – January 12, 2023, and February 27, 2023 – March 2, 2023. Furthermore, the parties are directed to file a joint status report regarding any conflicts with the proposed dates by November 21, 2022.

In addition, after reviewing the record, including the parties' disclosures, pretrial briefs, and the Court's Order denying the Defendant's Motion in Limine (DE 50) in preparation for trial, the Court would like to explore whether there is a fact question on proximate cause. See Hughes v. Children's Clinic, P. A., 269 S.C. 389, 398, 237 S.E.2d 753, 757 (1977) ("Negligence is not actionable unless it is a proximate cause of the injuries, and it may be deemed a proximate cause only when without such negligence the injury would not have occurred or could have been avoided."). As the parties know, Plaintiffs offer Dr. Jacob to show "that the medical evidence supports Mr. Lynn's diagnosis of Charcot joint disease and that the VA's providers departed from

the standard of care in urgently removing Mr. Lynn's right leg when 'there was never any direct evidence demonstrating osteomyelitis.'" (DE 50, p. 7; see also DE 6, p. 10, quoting DE 1-1, ¶ 36.) While the Court denied Defendant's motion in limine (DE 34), finding that "Dr. Jacobs has satisfactory knowledge, skill, experience, training, or education on the issue for which the opinion is proffered[,]" that finding does not establish Plaintiffs' burden to show by expert testimony whether osteomyelitis was the proximate cause of Mr. Lynn's injuries. See David v. McLeod Reg'l Med. Ctr., 367 S.C. 242, 247, 626 S.E.2d 1, 4 (2006) ("[T]he plaintiff must show that the defendants' departure from such generally recognized practices and procedures was the proximate cause of the plaintiff's alleged injuries and damages. (Citation omitted). The plaintiff must provide expert testimony to establish both the required standard of care and the defendants' failure to conform to that standard, ...").

Accordingly, the Court hereby authorizes and directs the parties to file briefs (supported by declarations of the parties' experts) on the question of whether Plaintiffs can (with the witness proffered for trial) establish their burden of proof for medical malpractice regarding the proximate cause of Lynn's injuries. The parties shall have until November 23, 2022, to brief the issue and to file any replies by December 1, 2022. Thereafter, the Court will consider the briefs to determine if judgment is appropriate under Rule 56(f), Fed. R. Civ. P.

AND IT IS SO ORDERED.

November 14, 2022
Florence, South Carolina

UNITED STATES DISTRICT COURT
DISTRICT OF SOUTH CAROLINA
CHARLESTON DIVISION

KEITH LYNN AND JENNIFER LYNN,
Plaintiffs,
vs. CASE NO. 2:20-cv-4277-JD
UNITED STATES OF AMERICA,
Defendant.

VIDEOCONFERENCE
DEPOSITION OF: ALLEN MARK JACOBS, DPM

DATE: March 11, 2022

TIME: 2:05 p.m.

LOCATION: 6400 Clayton Road
Suite 402
St. Louis, MO 63117

TAKEN BY: Counsel for the Defendant

REPORTED BY: KAREN NELLIUS, RPR
(Appearing via videoconference)

A. Yes.
Q. Okay. And you are unaware as to whether or not in South Carolina a podiatrist is allowed to perform surgeries and procedures above the ankle?
A. I am not.
Q. Okay. Just so the record is clear, you are not familiar with the South Carolina law on that issue; is that fair?
A. That's correct.
Q. Okay. Did you provide a fee schedule to Mr. Lynn's attorneys in anticipation of serving as an expert witness?
A. I would think.
Q. And what are your current rates? And if you want to break that down to an hourly rate or a deposition rate or a trial rate.
A. I don't have that sheet with me. I'm certain my girls provided it to plaintiffs' counsel. I would think they can provide you with a copy or I can obtain one if you need one.
Q. We will need one because the federal rules provide a requirement that that information be provided.
MR. TINKLER: I do have that. I can

studies that also would be consistent with Charcot's joint disease and no effort was made to establish that diagnosis.

More importantly to me is this issue of amputating the leg without any type of evaluation. You have to understand to a podiatrist losing a leg is like a physician losing a life. That's what we try to preserve, are legs. And dealing with many amputee patients, I don't think we should take the removal of a man's leg lightly. I think you want to see if there is any chance of salvaging that limb.

This is a patient that had no urgent need for amputation. Mr. Lynn was not febrile. He did not have an elevated white cell count. He was hemodynamically stable. His laboratory studies were unimpressive, and, in fact, were inconsistent with a necrotizing fascial infection. And based on an x-ray that was interpreted as being osteomyelitis without any proof of bone infection and based on a presumption that the gas on the CT scan that was visualized was representative of a necrotizing infection and not simply an infection with a gas-forming organism which would have presented the same way, no effort was made to

osteomyelitis. And if it was osteo, we don't know that because no one ever did anything to verify the diagnosis.

So that's my -- that's really where I'm focused, is the decision to do the amputation, particularly in a man who is stable. This was not a patient who was on death's door. I had a patient, as I said earlier, this year. His foot was gangrene and dead. He was febrile. He had like a 20,000 something white count. He was hemodynamically unstable. Mr. Lynn was far from that. He was far from that. And the patient I have right now in the hospital with a potential necrotizing fascial infection, infectious disease and I are going back and forth right now because she has got an initial negative CT scan but she has got some arguable signs and symptoms consistent with a necrotizing fascial infection. I'm going to see her this evening, and she may have to be an add-on if her CT comes back confirming that, yes, she has got problems, but we are going to open it up and look and confirm that she has a major issue, and we're going to debride her and do an incision and drainage but we are not going to -- well, I can't amputate legs anyway by law, but we are

not have an infection.

Q. Do you think that Mr. Lynn's amputation was a result of trying to treat osteomyelitis?

A. It's possible.

Q. Did you see --

A. You mean treating a Charcot that was, in fact, osteo? Is that what you are asking me?

Q. What I'm asking you is do you think that Dr. Brothers performed an amputation on Mr. Lynn to treat osteomyelitis?

A. That was part of his -- yes, because he states in his record that Mr. Lynn had osteomyelitis. Dr. Brothers made that diagnosis.

Q. Okay. Do you think that the osteomyelitis was in the foot region where the Charcot foot disease was?

A. I don't know that there was ever osteomyelitis anywhere. But if it was, it could have been in the foot, it could have been in the ankle, it could have been in the distal tibia and fibula.

Q. Okay. Do you believe that Dr. Brothers amputated the leg of Mr. Lynn to treat the necrotizing fascitis?

A. Yes.

Q. Dr. Jacobs, I'm going to ask if we can go off the record for a few minutes. I'm just going to look over a couple of things and try to get back as soon as I can on this. Okay?

A. Sure.

Q. Stretch or take a comfort break.

(A recess transpired.)

BY MR. BERLINSKY:

Q. I'm just going to try to close out the deposition, Dr. Jacobs. If I understand your testimony, then I'm just going to get a couple quick summaries.

I think that you testified that the blood glucose, the intermittent chills, the decreased energy, the decreased appetite, the fatigue, and the vomit, those are signs and symptoms of an infection?

A. Can be.

Q. Okay. And where you say in paragraph 4 that there were no signs and symptoms of infection -- symptoms of infection, we just went through that, that's not really as accurate based on what we just talked about, correct?

A. Correct.

Q. And as far as the decision of the

vascular surgeon to amputate the leg for necrotizing fascitis, that in and of itself is not a deviation in the standard of care of vascular surgery. Are you able to testify on that opinion?

A. Obviously you know as well as I do I cannot testify to vascular surgery standards of care.

Q. Okay. It sounds to me like you didn't see any evidence in the record that cleared up a presumptive finding of necrotizing fascitis and you think that was a requirement, correct?

A. No. What I'm suggesting is even if the diagnosis were that of necrotizing fascitis that there is still the opportunity to salvage a limb. Or other part of the body. I mean, it's not a disease you just get on the leg or the foot. There is the opportunity for salvation of that -- or preservation of that limb with an aggressive debridement, usually multiple debridements are required, but you can salvage the leg. So I'm saying even if there was a true diagnosis of necrotizing fascitis, because all we have is indirect presumptive evidence, that still does not mandate amputation of the limb, that you can salvage limbs with necrotizing fascitis. It's a

CERTIFICATE OF REPORTER

I, Karen Nellius, Court Reporter and Notary Public for the State of South Carolina at Large, do hereby certify that the foregoing transcript is a true, accurate, and complete record.

I further certify that I am neither related to nor counsel for any party to the cause pending or interested in the events thereof.

Witness my hand, I have hereunto affixed my official seal this 22nd day of March, 2022 at Charleston, Berkeley County, South Carolina.

_____

Karen Nellius, RPR

My Commission Expires

November 14, 2024

In The Matter Of:

Keith Lynn and Jennifer Lynn v.
United States of America

Thomas E. Brothers, MD
March 3, 2022

Barnett Reporting
meg.f.barnett@gmail.com

Min-U-Script® with Word Index

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
CHARLESTON DIVISION

KEITH LYNN AND
JENNIFER LYNN,)
)
Plaintiffs,)
)
vs.)
)
UNITED STATES OF AMERICA,)
)
Defendant.)

THE ZOOM DEPOSITION OF THOMAS E. BROTHERS, MD

DATE: Thursday, March 3, 2022

TIME: 2:00 p.m.

WITNESS
LOCATION: Via Zoom
Charleston, SC

REPORTER: Margaret F. Barnett
Court Reporter and Notary Public

are for. We can't rely on memory.

Well, can you just tell us, either from your recollection or your review of the records, how Mr. Keith Lynn presented and when he presented to you?

A. So he presented to us in consultation through the emergency department -- I did write down the date -- I think on the 15th of January 2019. He had presented with a swollen, inflamed, discolored right leg. The story was that he had a Charcot foot for which he was being followed in podiatry, that he had come in, been seen by them. And after their evaluation, he was unhappy with that evaluation and returned to the emergency department, where we were asked to see him.

We saw him and felt that he had evidence of a surgical urgency/emergency and required admission to the hospital for likely operative debridement versus amputation versus drainage. He had evidence of likely necrotizing fasciitis and myositis on his scan. In fact, that's why the emergency department physician had contacted us. Unfortunately, he also was anticoagulated, over-anticoagulated. He was on Coumadin and his level of anticoagulation was more than twice normal of what is desired.

So he was, therefore, readmitted to the

hospital, with the idea of being able to treat him and take care of this so he didn't lose his leg and his life. It felt necessary to start him on antibiotics and to reverse his anticoagulation. As I recall, he was not febrile at the time and his white count wasn't febrile in hemodynamically. He was doing well and his blood pressure was okay, and so it wasn't something that we had to take him emergently to the operating room to do.

Over the course of the next day and a half, he remained without going into sepsis or septic shock. We were able to reverse his anticoagulation to where it would then be safe to operate on him, and subsequently took him to the operating room, where, because of the extensive nature of his myonecrosis and the findings, we felt it was best -- I felt it was best to perform an above-knee -- excuse me, a below-knee amputation. He subsequently recovered from that, healed up and was able to go home. Unfortunately, a number of months later, he came back with something called heterotopic calcification and he required further surgical revision.

Q. When you referred to the findings of, what was it, myo what?

A. Myonecrosis or -- so necrotizing fasciitis

on a clinical finding, if I understand your testimony. Is that right?

A. I believe that's correct, yes.

Q. When you performed the amputation, is it my understanding that was a decision that was made once you, I guess, dissected or opened up the surgery and determined whether or not debridement and drainage would be an appropriate relief?

A. So I don't have -- that is my suspicion, but I do not have independent recollection of that, and I did not include that in my operative note. So that would be typically what I would do, but I do not specifically recall that in this instance.

Q. Again, the reason or the decision to amputate related to the gaseous tissues that were identified, that were suspicious of this necrotizing fasciitis or myositis. Is that correct?

A. Yes.

Q. And I know that -- taking away from the lawyers' perspective that an ankle bone is connected to the tibia and the fibula and it's all sort of interrelated. Taking that apart from the medical standpoint, did the amputation have anything to do with the treatment of the Charcot foot that Mr. Lynn was being treated for by podiatry?

CERTIFICATE OF REPORTER

I, Margaret F. Barnett, Professional Court Reporter and Notary Public for the State of South Carolina at Large, do hereby certify that the foregoing transcript is a true, accurate, and complete record of the testimony of the witness and of all objections made at the time of the examination.

I further certify that I am neither related to nor counsel for any party to the cause pending or interested in the events thereof.

Witness my hand, I have hereunto affixed my official seal this 7th day of March, 2022 at Charleston, Charleston County, South Carolina.

Margaret F. Barnett

Margaret F. Barnett
Notary Public
My Commission expires
February 25, 2030

Declaration of John Womack, MD
In the Matter of Lynn vs. United States of America

Nov 16,2021

I am a board certified orthopaedic surgeon with fellowship training in foot and ankle surgery. I have practiced almost exclusively foot and ankle surgery for the past 15 years in Greenville, South Carolina. I take care of patients with diabetic foot problems including Charcot arthropathy on a daily basis including diagnosis as well as both conservative and surgical management of these patients. I routinely treat diabetic infections of the lower extremity and perform below knee amputations as a necessary life saving measure for patients where appropriate. In addition I currently serve as the chairman of the Joint Podiatry Advisory Committee for the South Carolina State Department of Labor, Licensing, and Regulation at the pleasure of the governor of South Carolina as well as the State Board of Medical Examiners. Mr. Lynn would be a typical patient that I may encounter in my practice on a daily basis.

The scope of practice for podiatry in South Carolina does not include the treatment of overwhelming soft tissue infections above the level of the ankle joint or performing below knee amputations.

I have reviewed extensively the plaintiff's medical records from the VA Medical Center in Charleston from July of 2015 until December of 2020 including all of the outpatient and inpatient notes as well as laboratory tests available to me. I have also reviewed the patient's pertinent imaging studies performed at this institution that relates to the care of the patient's right lower extremity.

The patient and his wife then presented to the ER of the VA Medical Center in Charleston on 1/15/19, according to the intake nurse's note, seeking a second opinion about his right foot due to the increased swelling and pain in his right leg. Vascular surgery was consulted while the patient was in the ER for management of his right leg. The vascular surgery consultation dated 1/15/19 indicates that the patient had edema of his right lower extremity from the ankle to mid calf with erythematous blisters. I reviewed both the CT report and images from the CT of the right LE performed that day while the patient was in the ER which demonstrated a 7x12x4 cm abscess of the leg above the ankle level which contained both fluid and gas. Given the absence of an external wound this can only represent an overwhelming and life threatening soft tissue infection of the patient's leg. This conclusion is also supported by the appearance of the leg in photographs submitted by the plaintiff of his leg before the amputation was performed.

The infection seen on the CT scan of the patient's leg represents a large abscess with necrotizing soft tissue infection that is a life threatening condition. The accepted and recognized treatment options by surgically trained providers (orthopaedic surgeons, vascular surgeons and general surgeons) would be an attempt at drainage of the infection and removal of all dead tissue from the patient's leg or below knee amputation to remove the infection burden from the patient and prevent sepsis and death. Given the magnitude of the infection and the patient's multiple medical problems including poorly controlled diabetes as well as severe heart disease it is my opinion that incision and drainage with removal of the dead tissue in the leg was not a

viable option due to the patient's poor potential to heal this surgery and with such a debridement that the leg would not be functional due to the large amount of tissue that would need to be removed.

It is my medical opinion within a reasonable degree of medical certainty that Dr. Brothers and the vascular surgery team did not deviate from the standard of care when offering and performing a below knee amputation of this patient's right lower extremity as a life saving measure. Dr. Brothers met the standard of care.

The patient had an overwhelming abscess of his leg above his known Charcot foot deformity that was likely with his many comorbidities to become a life threatening condition if left unchecked. It is more likely than not that an incision and drainage of the infection would not have been successful and that the skin changes and mottling noted along with the CT findings likely represented a life threatening condition known as necrotizing soft tissue infection. The only cure for this condition is amputation in this clinical setting as radical debridement of the involved area would not have been successful.

It should be noted that the area of concern on the CT was a new problem above the known Charcot foot that the patient had been treated for previously. The records show that the patient was admitted for a diagnosis of cellulitis/leg abscess/ and osteomyelitis by the vascular surgery service. The reason for his amputation had nothing to do with his well established history of Charcot foot related to his diabetes but rather his overwhelming soft tissue infection around his tibia well above the area of Charcot in his foot.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing
is true and correct.
Executed this 18th day of November, 2022

(signed) John Worrel, MD JOHN WORRELL, MD
Print Your Name and Date

Declaration of Mark R. Jackson, M.D.

By background I am a board-certified vascular surgeon in the active practice of vascular surgery since completing my vascular surgery fellowship at the Walter Reed Army Medical Center in June of 1993. Upon completion of my vascular surgery fellowship I remained at Walter Reed Army Medical Center as a staff vascular surgeon, while also having appointments at the Uniformed Services University of the Health Sciences in Bethesda, MD as an Assistant Professor Surgery, and also while having an assignment at the Walter Reed Army Institute of Research. I was honorably discharged from the Army in 1997 at the rank of Lieutenant Colonel, and then resumed my vascular surgery career at the University of Texas Southwestern Medical Center in Dallas, where I was promoted to the rank of Associate Professor of Surgery while having an active vascular surgery practice at The Dallas North Texas Veterans Affairs Hospital, Parkland Memorial Hospital, and Zale Lipshy University Hospital. During this time I started an endovascular program within the Division of Vascular Surgery specializing in the then-new technology of abdominal aortic aneurysm stent graft repair. My academic credentials also include publication of over 70 original articles in peer- reviewed journals, book chapters, and published abstracts. I have also presented medical scientific work at national and regional vascular surgery meetings. In 2003 I moved to Greenville, SC were I have continued my career in vascular surgery in the community hospital setting, initially as a hospital-employed vascular surgeon, and now in independent private practice. I have extensive clinical experience treating patient with severe vascular disease of the legs, including performance of procedures to restore blood flow to the legs, and amputation procedures, such as was required for Lynn. I have also provided surgical treatment for many patients with severe infections of the legs, including necrotizing fasciitis. Such infections are often seen in patients with severe vascular disease of the legs.

11/20/2022

Exhibit D

In preparation of this report I have reviewed the case files which include close to 9,000 pages. I have also reviewed the source images of the X-rays and CT scans that were performed in the course of Lynn's care. I have read the expert report of Dr. Jacobs. I have read the depositions of Dr. Jacobs, Dr. Brothers, Dr. Ravenell, Mr. Lynn, and Mrs. Lynn.

Based upon my review of these records I have no doubt that Dr. Brothers and the vascular team arrived at the correct diagnosis of a necrotizing soft tissue infection (necrotizing fasciitis with myonecrosis) - a severe infection of the muscle and deep tissues of the leg. The CT scan findings of extensive gas and infected fluid in the leg muscle, extending well above the ankle and into the middle portion of the leg, clearly and unmistakably support the diagnosis of necrotizing fasciitis with myonecrosis. The accepted standard practice and procedure for this condition requires surgical treatment such as the below knee amputation as was performed by Dr.Brothers.

While the option of a more limited incision and drainage, or debridement, might be acceptable in a more limited infection, the extensive degree of infection in this case necessitated amputation of the leg. In cases of necrotizing fasciitis for which amputation is not performed, thereby leaving behind infected tissue, there is a substantial and fatal risk of uncontrolled spread of the infection throughout the body (sepsis) since all of the dead and infected tissue has not been surgically removed.

Given the severity and extent of Lynn's necrotizing fasciitis with myonecrosis, a below the knee amputation was the appropriate treatment and Dr.Brothers' care clearly met the standard of care.

11/20/2022

The correct diagnosis of necrotizing fasciitis with myonecrosis is independent of any podiatric issues related to either Charcot foot and/or osteomyelitis below the ankle - neither of which had any bearing on the need for below the knee amputation.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Executed this 20 day of November, 2022

(signed) _____ 11/20/2022

Mark R. Jackson, M.D.

DECLARATION OF JAN FRITZ, M.D.

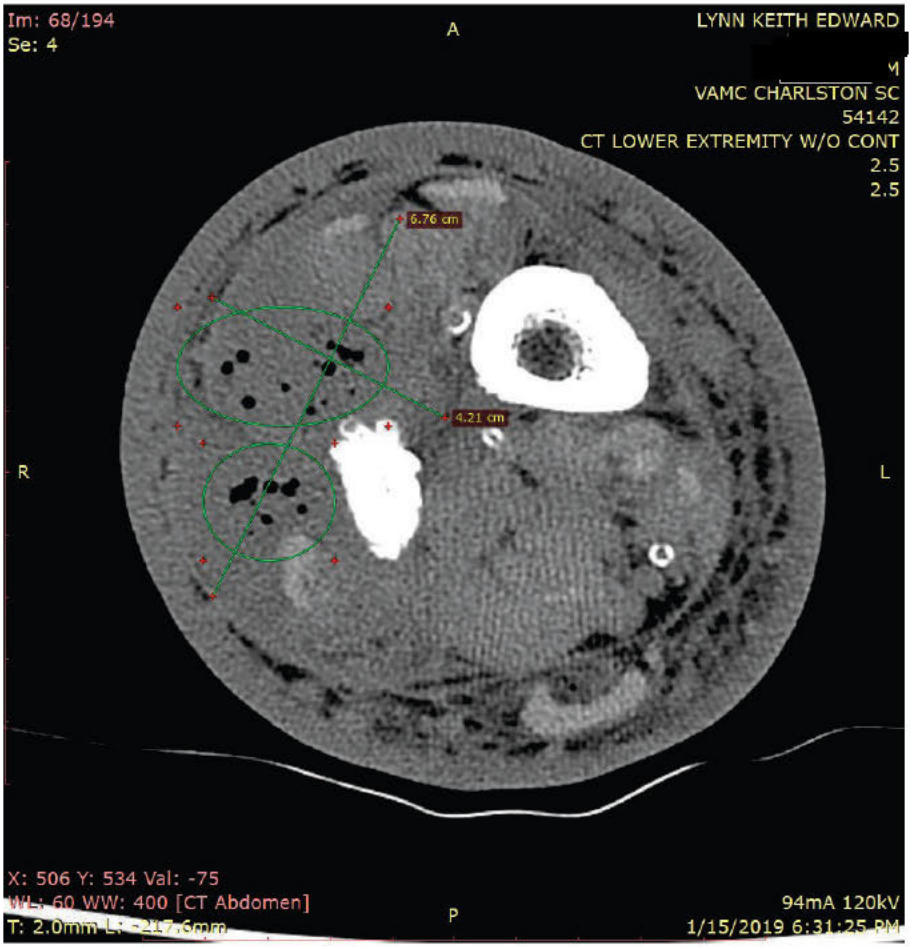
1. I am a physician and hold board certification in Diagnostic Radiology. I am an Associate Professor of Radiology at New York University Grossman School of Medicine in New York, New York. My attached curriculum vitae details my education, publications, and clinical background. I currently work as an attending physician at New York University Langone Health, Bellevue Hospital, and Gouverneur Hospital, all in New York, New York. I also serve as the Musculoskeletal Radiology Departmental Division Chief at New York University Langone Health in New York, New York. As part of my many years of clinical practice, I have completed many diagnostic interpretations of radiographs, ultrasonography, computer tomography, and magnetic resonance imaging examinations of patients with soft tissue infection, osteomyelitis, and joint infections. In addition, I have performed many percutaneous image-guided biopsy procedures to obtain tissue specimens for microbiological, laboratory, and pathological examination. As part of performing those procedures, I have assessed and treated many adult patients with acute and chronic musculoskeletal infections of soft tissues, bones, and joints. I am a member of multiple radiology societies, boards, professional organizations, and advisory committees, and I have published over 225 medical literature articles and given many presentations in the field of diagnostic radiology. Based on my education, clinical experience, training, and knowledge of medical literature, I am intimately familiar with the care and treatment of adult patients with the full spectrum of musculoskeletal infections.

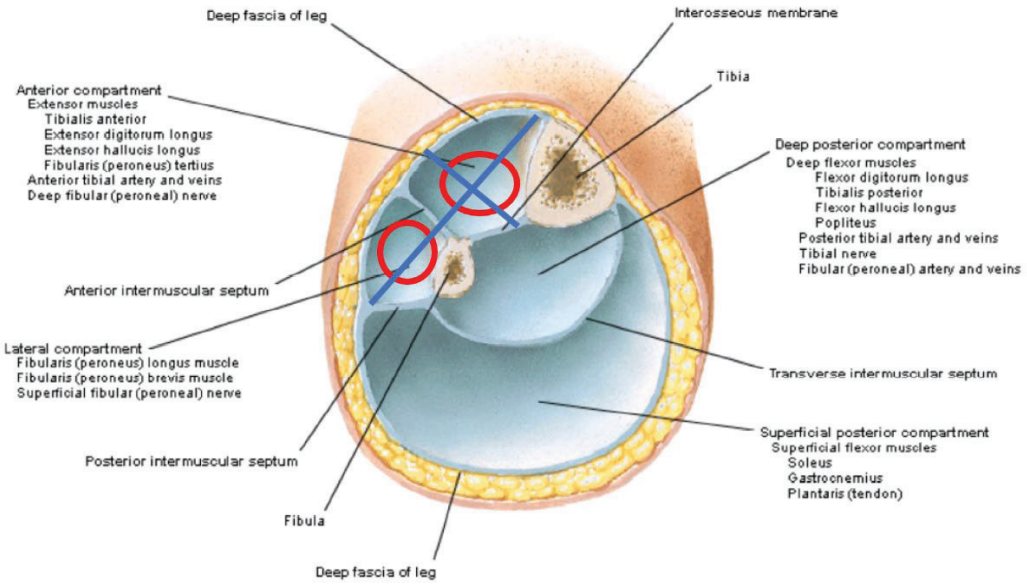
2. I reviewed select legal documents associated with this case. Documents that were provided to me for evaluation and forming my opinion included:
    - Complaint filed in this lawsuit alleging the deviation of the standard of care owed.
    - Declaration of Plaintiff's Expert Witness Allen Mark Jacobs
    - Pathology report dated 1/17/2019.
    - U.S. Department of Veterans Affairs Medical Records of Mr. Lynn.
    - Imaging studies of Mr. Lynn, including:
        - Radiographs of the **RIGHT** foot dated 7/23/2017
        - Radiographs of the **RIGHT** foot dated 6/21/2018
        - M.R.I. of the **RIGHT** foot dated 7/28/2018
        - Radiographs of the **RIGHT** and left foot dated 8/13/2018
        - Radiographs of the **RIGHT** foot dated 10/12/2018

- C.T. of the **RIGHT** lower extremity dated 1/15/2019

- Deposition Rahn Ravenell, MD, March 1, 2022
- Deposition Thomas E. Brothers, MD, March 3, 2022
- Deposition Allan Mark Jacobs, D.P.M., March 11, 2022
- Deposition Jennifer Lynn, March 31, 2022
- Deposition Keith Lynn, March 18, 2022

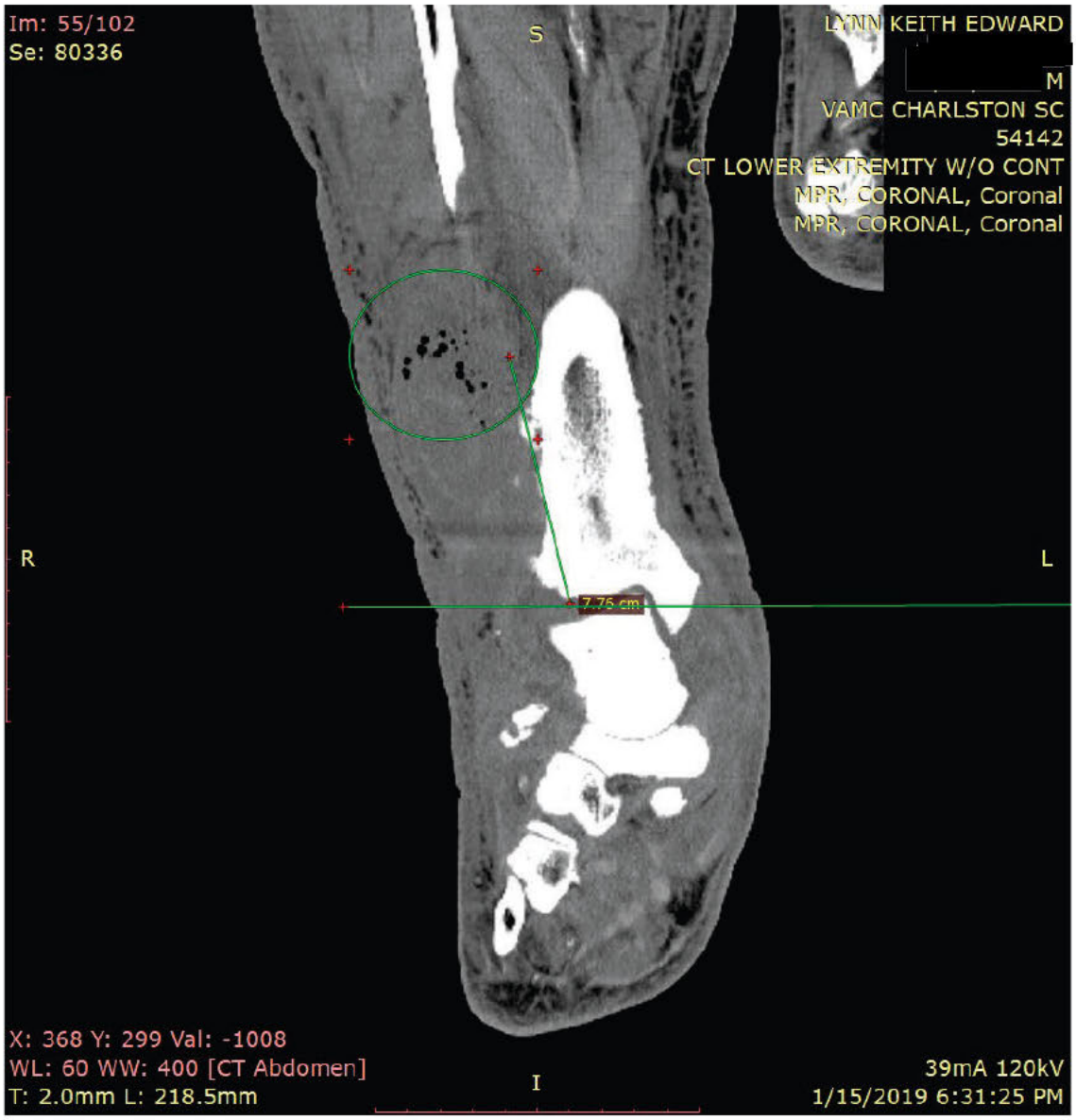
3. On 1/15/2019, Mr. Lynn presented with an acutely life-threatening, gas-producing, necrotizing infection involving soft tissues overlying the shin above the ankle joint. The gas-producing soft tissue infection and gangrenous muscle tissue necrosis are unequivocally demonstrated on the CT examination dated 1/15/21. The CT images demonstrated tissue necrosis and gas inside the muscle tissues and that the infection had already spread across two muscle compartments cross-sectionally and to the mid-region of the shin. The two circles below outline the soft tissue gas (dark spots). At that point, the cross-sectional spread of the infection measured approximately 6.7 x 4.2 m:



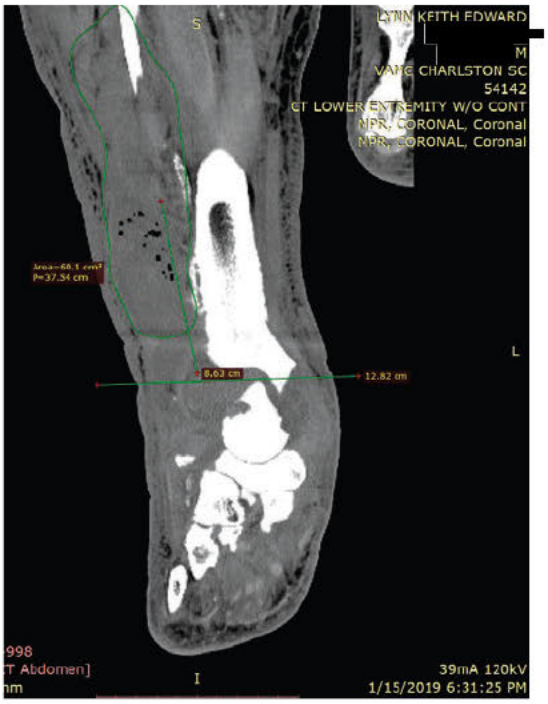


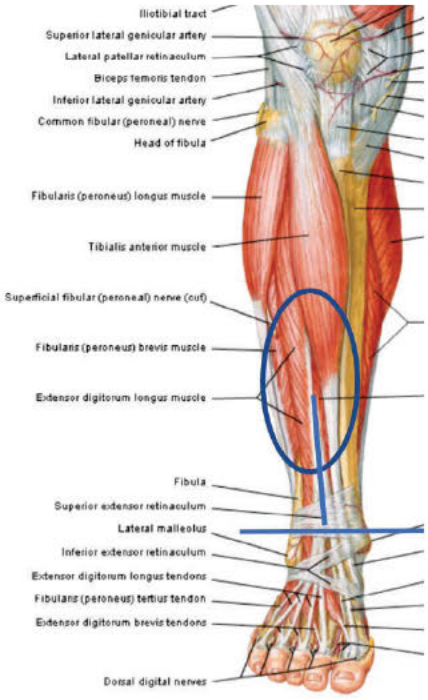
The constellation of findings was unequivocally diagnostic of gas gangrene, also known as infectious myonecrosis, which is a life-threatening surgical emergency. These infections are clinically feared due to fulminant tissue destruction, systemic toxicity, and high death rate. Dr. Brothers evaluated Mr. Lynn promptly and acutely, who was acutely sick at that time with systemic signs of toxicity, including at least one documented episode of vomiting and persistent nausea. Dr. Brothers immediately admitted Mr. Lynn and initiated broadband intravenous antibiotic treatment to combat systemic toxicity. On 1/17/2019, the vascular team documented systemically stable conditions of Mr. Lynn but persistent necrotizing shin infection, despite intravenous antibiotic broad-spectrum therapy, indicating that they were ineffective in controlling the infection. Following surgical consent, Dr. Brothers performed the life-saving below-the-knee amputation on 1/17/2019.

4. The center of the necrotizing soft tissue infection (circle) was located in the center of the shin, approximately 7.6 cm above the ankle joint line (horizontal line):



In head-to-foot direction, the inflammation of the necrotizing soft tissue infection extended to the mid-level of the shin over an area of approximately 8.6 cm:





5. The necrotizing gangrenous soft tissue infection of the shin musculature was spatially located above the ankle joint line and more remote than that from the midfoot, where previously Charcot foot and possible osteomyelitis were documented. Therefore, the necrotizing gangrenous soft tissue infection was independent of any podiatric-related issues and unrelated to Charcot foot and a previous diagnosis of possible midfoot osteomyelitis.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Executed this 21st day of November 2022

Jan Fritz, M.D., P.D., D.A.B.R., R.M.S.K.

UNITED STATES DISTRICT COURT
DISTRICT OF SOUTH CAROLINA
CHARLESTON DIVISION

Keith Lynn and Jennifer Lynn,

Plaintiffs,

vs.

United States of America,

Defendant.

Case No. 2:20-cv-04277-JD

DECLARATION OF ALLEN MARK JACOBS DPM, FACFAS, FAPWH

1. My career has been devoted to saving the lower extremities of patients. I was formerly the assistant head of the VA podiatry service in Washington, D.C. I am frequently consulted by other specialists, including emergency room physicians and surgeons, on questions involving potential amputation of lower limbs. A case like Mr. Lynn's falls squarely in my field of expertise. I refer the Court to my previous Declaration dated December 2, 2020, and my deposition dated March 11, 2022, for my qualifications and further elaboration of my opinions. In my opinion there was a deviation from the standard of care in by VA personnel in failing to arrive at a proper diagnosis and in amputating Mr. Lynn's leg below the knee rather than using alternative measures to arrive at a definitive diagnosis and treat accordingly. These departures from the standard of care constitute the proximate cause of Mr. Lynn's injury, i.e. the amputation of his leg.

2. The record reveals that Mr. Lynn definitely suffered from Charcot joint disease, which had manifested itself in June 2018. The condition grew progressively worse during the remainder of 2018.

3. When Mr. Lynn was seen in the ER on January 15, 2019, his CT suggested to the radiologist who interpreted it that he had osteomyelitis. Charcot joint disease and osteomyelitis are difficult to distinguish using radiographic images. The "gold standard" for establishing a

diagnosis of osteomyelitis is a bone biopsy. This was not performed. Nor do the operative report of January 17th or the resulting pathology report give any information to confirm the presence of osteomyelitis.

4. There was possibly some infective process going on - possibly even osteomyelitis. However, even if Mr. Lynn had osteomyelitis, the proper course of treatment would have been first to confirm the diagnosis and then determine the extent of the infection in the bone and consider the possible available less drastic treatments before amputating the leg. Mr. Lynn was hemodynamically stable, had no fever and no elevated white blood count. It is possible that an amputation might ultimately be called for, but that is speculative, given the record.

5. Similarly, there was never any diagnosis of necrotizing fasciitis or other immediately life-threatening infection. Even if the diagnosis of necrotizing fasciitis had been established by confirmation after performing an incision and inspection, the proper treatment would have required an evaluation of the extent of the problem and consideration of whether surgical debridement, rather than amputation, was the indicated treatment. Here, neither the operative report nor the pathology report indicate the presence of necrotic (dead) tissue.

6. In summary, by amputating Mr. Lynn's leg without first confirming a diagnosis and/or performing less drastic treatment measures, the VA medical personnel departed from the standard of care as widely accepted the in the relevant authoritative literature. That departure proximately caused Mr. Lynn's injury. My opinion is given with reasonable medical certainty.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on 11/18, 2022.

Dr. Allen Mark Jacobs, DPM,
FACFAS, FAPWH

UNITED STATES DISTRICT COURT
DISTRICT OF SOUTH CAROLINA
CHARLESTON DIVISION

Keith Lynn and Jennifer Lynn, Plaintiffs, vs. United States of America, Defendant.	Case No. 2:20-cv-04277-JD **PLAINTIFFS' MEMORANDUM IN REPLY TO DEFENDANT'S RULE 56(f) BRIEF**

Plaintiffs Keith Lynn and Jennifer Lynn submit this Memorandum in reply to Defendant's Rule 56(f) Brief to highlight the disputed facts that require trial. Defendant United States of America, which never moved for summary judgment before, argues that Plaintiffs failed to meet their burden to establish proximate cause: (1) because the testimony of Plaintiffs' podiatry expert, Dr. Allen Mark Jacobs, "focuses" on the condition of Mr. Lynn's foot and (2) because Mr. Lynn's leg was amputated due to a "life-threatening, necrotizing soft tissue infection in [his] calf and shin area"—a condition Dr. Jacobs "does not treat." Def.'s Br., ECF No. 58, at 2. While this may be Defendant's theory of the case,[1] Dr. Jacobs's testimony squarely contradicts it, creating genuine disputes of material fact that can only be resolved after subjecting the parties' witnesses to cross-examination and credibility determinations.

[1] Defendant states in its brief that it submitted proposed findings of fact and conclusions of law. Def.'s Br. 1. After a review of the communications from and preferences of this Court, Plaintiffs are unaware of any request or requirement to submit proposed findings and conclusions *before* the evidence is presented at trial. For that reason and because of Local Civil Rule 26.05, which states that "[p]roposed findings and conclusions should not be submitted with the pretrial brief ***unless requested by the court***," (emphasis added), Plaintiffs did not submit them. Further, Defendant did not serve its proposed findings and conclusions on Plaintiffs. For these reasons, Plaintiffs are concerned that Defendant provided the Court with improper argument on assumed testimony *ex parte* and request that the Court permit Plaintiffs to review Defendant's proposed findings and conclusions.

First, Dr. Jacobs's testimony does not "focus" on Mr. Lynn's foot, as Defendant argues. Rather, as supported by his two declarations and deposition testimony, his focus is on the universe of symptoms Mr. Lynn presented to the VA personnel before his amputation and the standard of care that Mr. Lynn should have received by VA personnel for those symptoms. Dr. Jacobs unequivocally established that his expertise—which includes decades of experience, prolific publication, and a stint with the VA—is with the "foot, ankle, and ***lower leg***," the area where Mr. Lynn's amputation was performed. ECF No. 39-2, at 5:22–23 (emphasis added); *see also* ECF No. 59-1, at ¶ 1 ("I am ***frequently consulted*** by other specialists, including emergency room physicians and surgeons, ***on questions involving potential amputation of lower limbs***." (emphasis added)). He led seminars about the management of infectious disease and diagnostic radiologic techniques relating to lower extremities. ECF No. 1-1, at 14–15. And he specified that he has experience treating osteomyelitis and necrotizing infections. *See* ECF No. 39-2, at 12:8–23 ("I have one patient in house now that I'm treating with a ***necrotizing infection*** of the foot. ***Of the leg, actually***. I had one earlier this year that resulted in a leg amputation. So actual ***necrotizing fascial*** infections are not common, ***but I see several a year***." (emphasis added)); *see also* ECF No. 1-1, at 15 (listing one of Dr. Jacobs's publications entitled "Management of Osteomyelitis."). Thus, at a minimum, a factual question exists as to whether Dr. Jacobs, whose "career has been devoted to saving the lower extremities of patients," can credibly support his fundamental opinions relating to duty and causation in this medical negligence case. ECF No. 59-1, at ¶ 1.

Second, Dr. Jacobs's fundamental opinion relating to causation is that the medical evidence did not, within a reasonable degree of medical certainty, support the amputation of Mr. Lynn's lower leg. ECF No. 59-1, at ¶ 1. Hence, VA personnel breached that duty when they amputated it. Defendant's factual assertion that the amputation was necessary because of a "necrotizing soft

tissue infection" is a (quite genuinely) disputed fact, and this Court need look no further than the VA's own medical records to appreciate that genuineness. In particular, the attending vascular surgeon who amputated Mr. Lynn's lower leg listed, ***after the amputation***, that Mr. Lynn's diagnoses were "osteomyelitis . . . [,] abscess, [and] cellulitis." USA DOCS_1145–46, Ex. A. In fact, the only mention of necrotizing fasciitis in the 8,948 pages of medical records that Defendant provided this Court in advance of trial was as a *provisional* diagnosis by another physician in a single consult request to the VA's vascular surgery department. USA DOCS_1744–45, Ex. B. According to that record, the attending vascular surgeon agreed upon an assessment and plan to treat "Osteomyelitis and Abscess," USA DOCS_1756, Ex. C, and he acknowledged this six days ***after the amputation***, USA DOCS_1757, Ex. D. Dr. Jacobs's causation opinion is premised on his review of these medical records and his vast experience as expressed above. As he reiterated in his November 18, 2022 declaration, "Mr. Lynn was hemodynamically stable, had no fever and no elevated white blood count." ECF No. 59-1, at ¶ 4. No bone biopsy or incision was performed, and the pathology report did not "indicate the presence of necrotic (dead) tissue." *Id.* at ¶¶ 3–4. This evidence, which must be viewed in a light most favorable to Plaintiffs, reasonably implies that VA personnel did not need to amputate Mr. Lynn's lower leg.

Third, crediting Defendant's witnesses over Plaintiffs' witnesses would require weighing the evidence and short-circuit a proper trial on the merits. Defendant invites error by not fully explaining the law and cherry-picking the evidence. As to the law: Defendant's reference to *International Bancorp, LLC v. Societe des Bains de Mer et du Cercle des Etrangers a Manaco*, 329 F.3d 359 (4th Cir. 2003), and the proposition that, "[w]hen a case is set for bench trial, the Court may draw inferences from established facts since the Court will act as the finder of fact anyway" does not fully explain what "established facts" actually are. Def's Br. 2. In that case, "the

parties did not contradict one another's proffered facts" and conceded that the district court could dispose of the matter on the paper record before it at the summary judgment hearing. *Int'l Bancorp*, 329 F.3d at 362. *International Bancorp* affirms the commonsense proposition from *Matter of Placid Oil Co.*, 932 F.2d 394, 398 (5th Cir. 1991), (also cited by Defendant) that "it makes little sense to forbid the judge from drawing inferences from the evidence submitted on summary judgment when that same judge will act as the trier of fact, ***unless those inferences involve issues of witness credibility or disputed material facts***." (Emphasis added). This case unquestionably presents the latter scenario because the parties present differing theories, creating issues of witness credibility and disputed material facts that require trial—not trial by affidavit. *See Tolen v. Cotton*, 572 U.S. 650, 660 (2014) (affirming the "fundamental principle" that "reasonable inferences should be drawn in favor of the non-moving party").

Defendant further attempts to "establish" facts in representing that Dr. Jacobs admitted that he "believe[s] that Dr. Brothers amputated the leg of Mr. Lynn to treat the necrotizing fasciitis." Def.'s Br. 3–4. But when Dr. Jacobs's testimony is read in its totality, he is not really admitting this at all. *See, e.g.*, ECF No. 39-2, at 22:16–18 ("[Mr. Lynn's] laboratory studies were unimpressive, and, in fact, were inconsistent with a necrotizing fascial infection."); *id.* at 46:16–19 ("Finding air density on an x-ray or CT scan does not equal a diagnosis of gas gangrene or a necrotizing fascial infection."); *id.* at 54:20–25 ("So I'm saying even if there was a true diagnosis of necrotizing fasciitis, because all we have is indirect presumptive evidence, that still does not mandate amputation of the limb, that you can salvage limbs with necrotizing fasciitis."); ECF No. 59-1, at ¶ 5 ("[T]here was never any diagnosis of necrotizing fasciitis or other immediately life-threatening infection."). Necrotizing fasciitis, according to Dr. Jacobs, can only be confirmed during surgery, and that simply was not done. ECF No. 39-2, at 55:4–8. Thus, the point Dr. Jacobs

makes in his testimony is that, based on the actual medical evidence in this case, whether Mr. Lynn actually had osteomyelitis or necrotizing fasciitis or even something else, Dr. Jacobs believes that Mr. Lynn's lower leg did not need to be amputated when it was. This opinion alone precludes summary judgment.

Accordingly, Plaintiffs respectfully request that they be permitted to review Defendant's proposed findings of fact and conclusions of law and to present their case at trial.

Respectfully submitted,

TINKLER LAW FIRM LLC

/s/ William P. Tinkler

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December 1, 2022

Counsel for Plaintiffs

CERTIFICATE OF SERVICE

I hereby certify that on December 1, 2022, I electronically filed **PLAINTIFFS' MEMORANDUM IN REPLY TO DEFENDANT'S RULE 56(f) BRIEF** through this Court's CM/ECF system. I understand that notice of this filing will be sent to all parties by operation of the Court's electronic filing system.

/s/ William P. Tinkler
William P. Tinkler (D.S.C. No. 11794)

Discharge Summaries

=36). Historically much decreased requirements while inpatient. 20U NPH BID, 10U aspart TID with meals with SSI and DM diet.

4. Iron Deficiency Anemia: Follows with anemia clinic. Holding off on IV iron infusions until complete clearance of signs of infection. Oral Fe given. Seen by GI consult and will consider outpt EGD/colon.

5. AKI on CKD3: quickly resolved with IVF. Back to baseline at discharge. Continue bicarb 1300mg BID and avoid nephrotoxic agents.

6. Factor V Leiden: therapeutic on coumadin so home regimen 5mg PO on M/W/F/S/Sun and 7.5mg On T/Th was continued.

7. Hypertension: BP low at 107/68 in ED but quickly returned to normal with IVF. Intitially home regiment held but was resumed at discharge. Home regiment lisinopril 40mg PO daily, Coreg 50mg BID, Lasix 20mg BID.

8. Chronic Low Back Pain: stable, home regiment cont during hospital course and was unchanged at discharge. Home regiment: Oxycodone SA 20mg BID, robaxin 1000mg q6hr prn, and pain contract with PCP.

9. CAD: no recent CP, stable on home regimen: ASA, atorvastatin 80mg PO daily

10. PTSD: reports stable on current regimen. Follows with psych in Goose Creek. NO change to outpt regiment: mirtazapine 45mg daily and topiramate with atarax prn

11. Asthma: stable, Recently evaluated by pulmonary 2/15, PFTs consistent with air- trapping. Possible mixed etiology given concurrent GERD, obesity, OSA. No change to homoe regiment: Symbicort BID with albuterol prn

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/es/ William H. Shelley III, MD 253
Attending Physician
Signed: 10/22/2019 09:51

LOCAL TITLE: Discharge Summary
ADMIN DATE: JAN 15, 2019 DISCH. DATE: JAN 23, 2019
STANDARD TITLE: DISCHARGE SUMMARY
DICT DATE: JAN 23, 2019@11:05 ENTRY DATE: JAN 23, 2019@11:05:47
DICTATED BY: QUINN,KRISTEN M ATTENDING: BROTHERS,THOMAS E
URGENCY: routine STATUS: COMPLETED

DISCHARGE SUMMARY

DISCHARGE DIAGNOSIS:

Please enter the primary diagnosis during this hospitalization. osteomyelitis

Discharge Summaries

Printed On Aug 2, 2021

Please enter key secondary diagnoses during this hospitalization. abscess, cellulitis

Please indicate additional medical problems that have been addressed during this hospitalization
PROCEDURES PERFORMED DURING EPISODE OF CARE:
Right BKA 1/17

HPI:

47 y/o with Uncontrolled DM (A1C 10.6) with Peripheral Neuropathy, CAD s/p MI and Stent placement, Factor V Leiden Mutation, Sleep Apnea on BiPAP, HTN, HLD, GERD, Chronic Pain, and PTSD with a PMH of CVA x 4, Bilateral Lower Extremity DVT on lifelong Coumadin, and Repair of Bilateral Tibial Fractures s/p MVC complicated by MRSA infection and subsequent removal of hardware from LLE presents to ED with complaint of right leg pain associated with redness, warmth, and swelling. Right leg pain has been a chronic problem since July '18, at which time he was treated for Gout. He was then diagnosed with R Charcot foot later that month. Since that time, his right foot has continued to be bothersome, painful at times. He has been followed by Podiatry. He began using a CROW boot last fall until approximately 6 weeks ago when he was instructed to be NWB on the RLE and began using a wheelchair for mobility. Approximately 4 days ago, he reports worsening pain in his right leg with an increase in swelling and varying redness and discoloration of his lower leg, foot, and ankle. The pain and swelling continued to get worse, and he was concerned about the redness and warmth. He was evaluated by Podiatry today and is awaiting a new CROW boot. He states that he had a negative DVT study following his visit with Podiatry, but remains concerned about possible infection and is requesting further evaluation. Patient states he was directed to ED by patient advocate. He reports intermittent chills for the past month and decreased energy and appetite with fatigue in the past 4 days. He reports vomiting yesterday, but denies nausea and vomiting today. He denies fevers, sweats, lightheadedness, dizziness, palpitations, dyspnea, abdominal pain, diarrhea, constipation, bleeding, open leg wounds, and recent injuries.

PAST MEDICAL HISTORY:

1. Essential hypertension (SNOMED CT 59621000)	11/12/15
HERNDON,PAMELA	
2. ALLERGIC RHINITIS NOS	02/28/07
COLEY,IRENE B	
3. Obesity (SNOMED CT 414916001)	11/18/15
COBB,DANIEL B	
CLASS III, BMI 40	
4. Asthma (SNOMED CT 195967001)	11/08/17
HAYGOOD,ALLEN R	
5. GERD	12/11/00
COLEY,IRENE B	
6. Hyperlipidemia (SNOMED CT 55822004)	09/06/16

Consult Requests

Printed On Aug 2, 2021

Current PC Provider: HERNANDEZ-ALICEA,WILLIAM
Current PC Team: GCR PACT 06 MD *WH*
Current Pat. Status: Outpatient
UCID: 534_3190237
Primary Eligibility: SERVICE CONNECTED 50% to 100%(VERIFIED)
Patient Type: SC VETERAN
OEF/OIF: NO

Service Connection/Rated Disabilities
SC Percent: 100%
Rated Disabilities: ANXIETY DISORDER (100%)
ARTERIOSCLEROTIC HEART DISEASE (60%)
MIGRAINE HEADACHES (30%)
PARALYSIS OF ALL RADICULAR NERVE GROUPS (20%)
PARALYSIS OF EXTERNAL POPLITEAL NERVE (10%)
HYPERTENSIVE VASCULAR DISEASE (10%)

Order Information
To Service: VASCULAR SURGERY OUTPT
From Service: 4BS SURG
Requesting Provider: TAYLOR,MICHAEL L
Service is to be rendered on an INPATIENT basis
Place: Consultant's choice
Urgency: Routine
Clinically Ind. Date: Jan 15, 2019
DST ID:
Orderable Item: VASCULAR SURGERY OUTPT
Consult: Consult Request
Provisional Diagnosis: Necrotizing Fasciitis(ICD-10-CM M72.6)
Reason For Request:
LYNN,KEITH EDWARD [redacted] DOB: [redacted]
4BS SURG B424-16
DS - Disabilities
Eligibility: SERVICE CONNECTED 50% to 100% VERIFIED
Total S/C %: 100

HEMORRHAGE OF THE BRAIN	10%
S/C	
MIGRAINE HEADACHES	30%
S/C	
ARTERIOSCLEROTIC HEART DISEASE	30%
S/C	
HYPERTENSIVE VASCULAR DISEASE	10%
S/C	
ANXIETY DISORDER	100%
S/C	

Combat Veteran Status: None Indicated
Enrollment Priority: GROUP 1

Consult Requests

Printed On Aug 2, 2021

ATTENDING: N Glover MD
DIAGNOSIS: necrotizing fasciitis
REASON FOR REQUEST: eval and treat

PERTINENT INFORMATION: as discussed

The patient understands this consult may be answered electronically.
What is the best time for the patient to be reached
to schedule this consult?
Evening (4p-8p)

Inter-facility Information
This is not an inter-facility consult request.

Status: COMPLETE
Last Action: COMPLETE/UPDATE

Facility

Activity	Date/Time/Zone	Responsible Person	Entered By
CPRS RELEASED ORDER	01/15/19 23:08	TAYLOR,MICHAEL L	TAYLOR,MICHAEL L
INCOMPLETE RPT Note# 40146678	01/15/19 23:25	MUNACO,SANDRA S	MUNACO,SANDRA S
COMPLETE/UPDATE Note# 40146678	01/16/19 02:39	MUNACO,SANDRA S	MUNACO,SANDRA S

Note: TIME ZONE is local if not indicated

LOCAL TITLE: VASCULAR SURGERY CONSULT/HISTORY&PHYSICAL
STANDARD TITLE: VASCULAR SURGERY CONSULT
DATE OF NOTE: JAN 15, 2019@23:09 ENTRY DATE: JAN 15, 2019@23:10:14
AUTHOR: MUNACO,SANDRA S EXP COSIGNER:
URGENCY: STATUS: COMPLETED

HISTORY AND PHYSICAL
ATTENDING PHYSICIAN: BROTHERS,THOMAS E

LEVEL OF SUPERVISION: Patient discussed with Dr. S. Allen, who discussed with Attending, who concurs with findings and plan.

CHIEF COMPLAINT: Came to the ED to get a second opinion about my foot.

Consult Requests

Printed On Aug 2, 2021

involvement of the distal extensor digitorum longus muscle.

Large complex fluid collection surrounding the ankle and hindfoot, contiguous with and not clearly separable from the abscess at the lateral ankle and distal calf, presumably also reflecting abscess. There is osseous destruction anteriorly at the calcaneus with periosteal reaction at the cuboid middle and lateral cuneiforms and navicular, compatible with osteomyelitis.

Diffuse density throughout the subcutaneous fat of the distal calf and ankle consistent with cellulitis.

VTE PROPHYLAXIS:
Pharmacologic VTE prophylaxis:
to be started on admission (score > or = 4)
Mechanical VTE prophylaxis:
to be started on admission

ASSESSMENT AND PLAN:
Discussed with Dr. S. Allen, who discussed with Attending, who is in agreement with assessment and plan.

RLE Osteomyelitis and Abscess:
- Admit to ward, Vascular Surgery
- IV Antibiotics: Zosyn 3.375 mg IV Q 6hrs and Vancomycin 1250 mg IV Q 12hrs
- Xray Right knee to evaluate stability of existing hardware
- Phytonadione 5 mg SQ x 1 dose and repeat Coags in am
- Diabetic diet, then NPO after MN for possible OR 1/16/19
- NS @ 100 ml/hr
- Consult Psychiatry in the am prior to any OR
- Repeat CBC and BMP in the am
- Pain control: Oxycodone 15 mg PO Q4hrs PRN and Dilaudid 0.5 mg IV Q2hrs PRN
- Continue home meds to prevent opioid-induced constipation

Uncontrolled Diabetes:
- Hold home meds: Metformin, Insulin
- BG monitoring AC & HS when taking PO and Q 4hrs when NPO
- High dose sliding scale
- Transfer to ICU for Insulin gtt if BG > 400
- Consider Endocrine Consult in the am

Factor V Leiden Mutation w/ PMH of Multiple DVT
- Hold Warfarin upon admission
- Phytonadione 5 mg SQ x 1 dose (INR 4.2) for possible OR 1/16/19 and repeat Coags in am
- Begin Heparin 5000u SQ Q8hrs for DVT prophylaxis

Sleep Apnea

Consult Requests

Printed On Aug 2, 2021

- Consult RRT to evaluate patient and initiate home BiPAP as needed

CAD/HTN/HLD
- Continue home meds with the exception of Lasix and Lisinopril
- Continue ASA

PTSD/Depression
- Continue home meds
- Consult Psychiatry in the am

GERD
- Continue home meds

Cyst
- Removed from R neck by Dermatology 1/2/19 with instructions for suture removal in 7-10 days. Will need suture removal during this admission.

/es/ SANDRA S MUNACO, NP
NURSE PRACTITIONER
Signed: 01/16/2019 02:39

Receipt Acknowledged By:
01/21/2019 11:10 /es/ SHELBY LYNN ALLEN, MD
RESIDENT
01/18/2019 18:46 /es/ THOMAS E BROTHERS, MD
ATTENDING SURGEON

========== END ==========

Current PC Provider: HERNANDEZ-ALICEA,WILLIAM
Current PC Team: GCR PACT 06 MD *WH*
Current Pat. Status: Outpatient
UCID: 534_3183332
Primary Eligibility: SERVICE CONNECTED 50% to 100%(VERIFIED)
Patient Type: SC VETERAN
OEF/OIF: NO

Service Connection/Rated Disabilities
SC Percent: 100%
Rated Disabilities: ANXIETY DISORDER (100%)
ARTERIOSCLEROTIC HEART DISEASE (60%)
MIGRAINE HEADACHES (30%)
PARALYSIS OF ALL RADICULAR NERVE GROUPS (20%)

PATIENT NAME AND ADDRESS (Mechanical Imprinting, if available)
LYNN,KEITH EDWARD
108 RUDOLPH CT
RIDGEVILLE, SOUTH CAROLINA 29472

VISTA Electronic Medical Documentation
Printed at CHARLESTON VAMC

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
CHARLESTON DIVISION

Keith Lynn and Jennifer Lynn, Plaintiffs, v. United States of America, Defendant.	**CA: 2:20-cv-04277-JD** **OPINION AND ORDER**

This Federal Tort Claims Act ("FTCA") case involves Plaintiffs Keith Lynn ("Mr. Lynn") and Jennifer Lynns' ("Mrs. Lynn") (collectively "Plaintiffs") claims for medical malpractice against Defendant United States of America ("Defendant" or "United States"). Their claims arise out of the below-knee amputation of Mr. Lynn's leg at the Charleston, South Carolina, VA Hospital. This case was set for a bench trial the week of November 14, 2022. (DE 48.) On November 11, 2022, Plaintiffs filed an Emergency Consent Motion for a Trial Continuance (DE 54) requesting that the trial scheduled for Monday, November 14, 2022, through Friday, November 18, 2022, be continued due to the illness of Plaintiffs' lead counsel. The Court granted the emergency motion to continue the trial. (DE 55.) However, after reviewing the record, including the parties' disclosures, pretrial briefs, and the Court's Order denying the Defendant's Motion in Limine (DE 50) in preparation for trial, the Court directed the "parties to file briefs (supported by declarations of the parties' experts) on the question of whether Plaintiffs can (with the witness proffered for trial) establish their burden of proof for medical malpractice regarding the proximate cause of [Mr.] Lynn's injuries." (DE 55.)

Defendant filed a United States Rule 56(f) Brief (DE 58), which the Court accepts as responsive to its November 14, 2022, order (DE 55), and Plaintiffs filed a Memorandum in

Response to the order. (DE 59.) The parties have also filed replies thereto. (DE 62, 63) After reviewing the same and the record, the Court grants Defendant Summary Judgment pursuant to Rule 56(f), Fed. R. Civ. P., for the reasons stated herein.

BACKGROUND

Mr. Lynn is a fifty-one-year-old former member of the United States Navy who was honorably discharged in June 1997 after approximately seven and one-half years of service. Mr. Lynn is eligible to receive medical care from the Department of Veterans Affairs ("VA") as a benefit of his naval service. (DE 1, ¶ 1.) According to Plaintiffs, on or about January 15, 2019, Mr. Lynn presented to the VA's Charleston facility with pain and swelling of his right leg. (Id. at ¶ 8.) At that time, Mr. Lynn had a history of pain and swelling of his leg and was being monitored by podiatrists at the VA for a diagnosis of Charcot's joint disease. (Id.) After presentation on January 15, 2019, Plaintiffs' Complaint alleges the non-podiatry staff at the VA diagnosed his condition as osteomyelitis and performed a below the knee amputation of Mr. Lynn's right leg.[1] (Id. at ¶ 9.) Further, Plaintiffs' Complaint alleges "there was insufficient evidence to support a diagnosis of osteomyelitis and the amputation performed on January 17, 2019, was unnecessary."[2] (DE 1, ¶ 10.)

On the other hand, Defendant contends that Mr. Lynn's leg was amputated due to a life-threatening, necrotizing soft tissue infection in the calf and shin area. (DE 58, p. 2.) Dr. Thomas E. Brothers, M.D. (Dr. "Brothers"), Mr. Lynn's treating vascular surgeon, testified that he

[1] According to the Defendant, Mr. Lynn's medical records indicate that he had the below knee amputation on January 17, 2019, and then in June 2019, he had a revision surgery due to heterotopic calcification of the amputated bone, which led to an above the knee revision surgery. (DE 34, p. 3.)

[2] Plaintiffs allege "a factual question exists as to whether [Plaintiffs' expert] whose 'career has been devoted to saving the lower extremities of patients,' can credibly support his fundamental opinions relating to duty and causation in this medical negligence case." (DE 63, p. 2.)

amputated Keith Lynn's leg because Lynn "had evidence of likely necrotizing fasciitis and myositis on his scan."[3] (DE 58-2, pp. 10-11.) Dr. Jacobs does not dispute this testimony stating he "believed Dr. Brothers amputated the leg of Mr. Lynn to treat the necrotizing fasciitis[.]" (DE 58-1, p. 10.) Furthermore, Defendant's expert Dr. Jackson, a vascular surgeon, opined that "[g]iven the severity and extent of Lynn's necrotizing fasciitis with myonecrosis, a below the knee amputation was the appropriate treatment and Dr. Brothers' care clearly met the standard of care." Moreover, Defendant's expert Dr. Womack, an orthopedic surgeon, opined, "[t]he reason for his amputation had nothing to do with his well established history of Charcot foot related to his diabetes but rather his overwhelming soft tissue infection around his tibia well above the area of Charcot in his foot." (DE 58-3.) Dr. Womack opined "[i]t is more likely than not that an incision and drainage of the infection would not have been successful and that the skin changes and mottling noted along with the CT findings likely represented a life threatening condition known as necrotizing soft tissue infection. The only cure for this condition is amputation in this clinical setting as radical debridement of the involved area would not have been successful." (Id.)

In addition, Dr. Fritz, Defendant's expert radiologist, opined, "Mr. Lynn presented with an acutely life-threatening, gas-producing, necrotizing infection involving soft tissues overlying the shin above the ankle joint." (DE 58-5.) He further opined that, "[t]he necrotizing gangrenous soft tissue infection of the shin musculature was spatially located above the ankle joint line and more remote than that from the midfoot, where previously Charcot foot and possible osteomyelitis were documented. Therefore, the necrotizing gangrenous soft tissue infection was independent of any

[3] In addition to the testimony of Dr. Brothers, Defendant proffers declarations from John Womack, M.D. (Dr. "Womack") a board certified orthopedic surgeon, Mark R. Jackson, M.D. (Dr. "Jackson") a board certified vascular surgeon, and Jan Fritz, M.D. ("Dr. Fritz") a board certified radiologist in support of summary judgment.

podiatric-related issues and unrelated to Charcot foot and a previous diagnosis of possible midfoot osteomyelitis." (DE 58-5.)

On December 9, 2020, Plaintiffs filed this action claiming medical negligence under the FTCA, and they retained Dr. Allen Mark Jacobs ("Dr. Jacobs") to provide his opinion. (DE 1.) Plaintiffs' sole expert, Dr. Jacobs, a podiatrist with over 40 years of experience treating patients who suffer from diabetes, neuropathy and Charcot joint disease, performed a review of Mr. Lynn's medical records from the VA and opined,

> with a reasonable degree of medical certainty that '[t]he medical records indicate clinical signs, symptoms, and radiographic and imaging changes consistent with Charcot's joint disease' and that 'there was never any direct evidence demonstrating osteomyelitis, and the urgent removal of Mr. Lynn's right leg was neither indicated nor necessary and was a departure from the applicable standard of care.'

(DE 1-1, ¶¶ 11, 36.) However, during his deposition, Dr. Jacobs was examined on the decision of the vascular surgeon to amputate the leg for necrotizing fasciitis, and whether that was a deviation in the standard of care of vascular surgery. (DE 39-2, p. 15-16, 53:25-54:4.) Dr. Jacobs testified that "[o]bviously you know as well as I do I cannot testify to vascular surgery standards of care." (DE 39-2, p. 16, 54:5.)

LEGAL STANDARD

Federal Rule of Civil Procedure 56

"After giving notice and a reasonable time to respond, the court may: (1) grant summary judgment for a nonmovant; (2) grant the motion on grounds not raised by a party; or (3) consider summary judgment on its own after identifying for the parties material facts that may not be genuinely in dispute." Fed. R. Civ. P. 56(f). The party seeking summary judgment bears the initial burden of demonstrating that there is no genuine issue of material fact. See Celotex Corp. v. Catrett, 477 U.S. 317, 323, 106 S. Ct. 2548, 91 L. Ed. 2d 265 (1986). "A fact is 'material' if proof

of its existence or non-existence would affect disposition of the case under applicable law. An issue of material fact is 'genuine' if the evidence offered is such that a reasonable jury might return a verdict for the non-movant." Wai Man Tom v. Hosp. Ventures LLC, 980 F.3d 1027, 1037 (4th Cir. 2020) (citation omitted).

Only reasonable inferences from the evidence need be considered by the court because "[i]t is the province of the jury to resolve conflicting inferences from circumstantial evidence. Permissible inferences must still be within the range of reasonable probability, however, and it is the duty of the court to withdraw the case from the jury when the necessary inference is so tenuous that it rests merely upon speculation and conjecture." Sylvia Dev. Corp. v. Calvert Cty., 48 F.3d 810, 818 (4th Cir. 1995). Whether an inference is reasonable cannot be decided in a vacuum; it must be considered "in light of the competing inferences" to the contrary. See Matsushita Elect. Indus. Co. v. Zenith Radio Corp., 475 U.S. 574, 588, 89 L. Ed. 2d 538, 106 S.Ct. 1348 (1986).

> In the end, the non-moving party must do more than present a 'scintilla' of evidence in its favor. Rather, the non-moving party must present sufficient evidence such that 'reasonable jurors could find by a preponderance of the evidence' for the non-movant, 'for an apparent dispute is not 'genuine' within contemplation of the summary judgment rule unless the non-movant's version is supported by sufficient evidence to permit a reasonable jury to find the facts in his favor.'

Sylvia Dev. Corp., 48 F.3d at 818 (quoting Stone v. University of Maryland Medical Sys. Corp., 855 F.2d 167, 175 (4th Cir. 1988) (internal citation omitted). Thus, if the evidence is "merely colorable" or "not significantly probative," a motion for summary judgment may be granted. Id.

Accordingly, the court may grant summary judgment only if it concludes that the evidence could not permit a reasonable jury to return a favorable verdict. An assertion of a genuine dispute of material fact must be supported by citations to materials in the record, including to depositions, documents, electronically stored information, affidavits, stipulations, admissions, answers to interrogatories, or to other materials, or by showing that the materials cited do not establish the

absence or presence of a genuine dispute, or that an adverse party cannot produce admissible evidence to support the fact. See Fed. R. Civ. P. 56(c)(1). The court only needs to consider the cited materials, but may consider other materials in the record. Id. at 56(c)(3). The plaintiff is entitled to have the credibility of all his evidence presumed. See Shaw v. Stroud, 13 F.3d 791, 798 (4th. Cir 1994) (quoting Miller v. Leathers, 913 F.2d 1085, 1087 (4th Cir. 1900)). When deciding summary judgment, the record must be viewed in the light most favorable to the party against whom summary judgment is sought. See Evans v. Techs. Applications & Serv. Co., 80 F.3d 954, 958 (4th Cir. 1996).

DISCUSSION

As noted above, this Court issued an order authorizing and directing the "parties to file briefs (supported by declarations of the parties' experts) on the question of whether Plaintiffs can (with the witness proffered for trial) establish their burden of proof for medical malpractice regarding the proximate cause of [Mr.] Lynn's injuries." (DE 55, citing David v. McLeod Reg'l Med. Ctr., 367 S.C. 242, 247, 626 S.E.2d 1, 4 (2006) ("[T]he plaintiff must show that the defendants' departure from such generally recognized practices and procedures was the proximate cause of the plaintiff's alleged injuries and damages. The plaintiff must provide expert testimony to establish both the required standard of care and the defendants' failure to conform to that standard, ..." (internal citation omitted)).) In response to the Court's directive, Plaintiffs contend they can and offer a declaration of Dr. Jacobs. (DE 59-1.) That declaration states in pertinent part:

> 2. The record reveals that Mr. Lynn definitely suffered from Charcot joint disease, which had manifested itself in June 2018. The condition grew progressively worse during the remainder of 2018.
>
> 3. When Mr. Lynn was seen in the ER on January 15, 2019, his CT suggested to the radiologist who interpreted it that he had osteomyelitis. Charcot joint disease and osteomyelitis are difficult to distinguish using radiographic images. The 'gold standard' for establishing a diagnosis of osteomyelitis is a bone biopsy. This was

> not performed. Nor do the operative report of January 17th or the resulting pathology report give any information to confirm the presence of osteomyelitis.
>
> 4. There was possibly some infective process going on - possibly even osteomyelitis. However, even if Mr. Lynn had osteomyelitis, the proper course of treatment would have been first to confirm the diagnosis and then determine the extent of the infection in the bone and consider the possible available less drastic treatments before amputating the leg. . . . It is possible that an amputation might ultimately be called for, but that is speculative, given the record.

(DE 59-1.) Given the record before the Court, Plaintiffs' reliance on Dr. Jacobs' declaration coupled with his deposition testimony that "[he] cannot testify to vascular surgery standards of care[]" (DE 39-2, p. 16, 54:5) is insufficient to create a genuine issue of material fact to survive summary judgment.

"A physician commits malpractice by not exercising that degree of skill and learning that is ordinarily possessed and exercised by members of the profession in good standing acting in the same or similar circumstances." David v. McLeod Reg'l Med. Ctr., 367 S.C. at 247, 626 S.E.2d at 3-4. "Additionally, medical malpractice lawsuits have specific requirements that must be satisfied in order for a genuine factual issue to exist. Specifically, a plaintiff alleging medical malpractice must provide evidence showing (1) the generally recognized and accepted practices and procedures that would be followed by average, competent practitioners *in the defendants' field of medicine* under the same or similar circumstances, and (2) that the defendants *departed from the recognized and generally accepted standards*." Id. (emphasis added). "Also, the plaintiff must show that the defendants' departure from such generally recognized practices and procedures was the proximate cause of the plaintiff's alleged injuries and damages. The plaintiff *must* provide expert testimony to establish both the required standard of care and the defendants' failure to conform to that standard, unless the subject matter lies within the ambit of common knowledge so that no special learning is required to evaluate the conduct of the defendants." Id. (internal citation omitted) (emphasis added).

Defendant argues "because Mr. Lynn's leg was amputated by a vascular surgeon due to a life-threatening, necrotizing soft tissue infection in the calf and shin area, the Lynns are unable to meet their burden to establish proximate cause with their sole expert—a podiatrist who does not treat such conditions and whose testimony focuses on the condition of Mr. Lynn's foot." (DE 58, p. 2.) Nevertheless, Plaintiffs contend Dr. Jacobs's testimony squarely contradicts Defendant's theory of the case, "creating genuine disputes of material fact that can only be resolved after subjecting the parties' witnesses to cross examination and credibility determinations." (DE 63, p. 1.) According to Dr. Jacobs,

> The record reveals that Mr. Lynn definitely suffered from Charcot joint disease . . . When Mr. Lynn was seen in the ER on January 15, 2019, his CT suggested to the radiologist who interpreted it that he had osteomyelitis. Charcot joint disease and osteomyelitis are difficult to distinguish using radiographic images. The 'gold standard' for establishing a diagnosis of osteomyelitis is a bone biopsy. This was not performed. Nor do the operative report of January 17th or the resulting pathology report give any information to confirm the presence of osteomyelitis.

(DE 59-1.) However, this factual dispute is not dispositive of the question on summary judgment here. "[I]t is the duty of the court to withdraw the case from the jury when the necessary inference is so tenuous that it rests merely upon speculation and conjecture." Sylvia Dev. Corp., 48 F.3d at 818. Whether an inference is reasonable cannot be decided in a vacuum; it must be considered "in light of the competing inferences" to the contrary. See Matsushita Elect. Indus. Co., 475 U.S. at 588.

Defendant has met its burden on summary judgment by demonstrating that there is no genuine issue of material fact. See Celotex Corp., 477 U.S. at 323. Dr. Brothers testified that he amputated Mr. Lynn's leg due to a necrotizing soft tissue infection (DE 58-2, p. 5), not osteomyelitis. Dr. John Womack, an orthopedic surgeon, stated, "the CT [of Mr. Lynn's leg] demonstrated a 7x12x4 cm abscess of the leg above the ankle level which contained fluid and gas.

Given the absence of an external wound this can only represent an overwhelming and life threatening soft tissue infection of the patient's leg." (DE 58-3.) Dr. Womack further opines that:

> The patient had an overwhelming abscess of his leg above his known Charcot foot deformity that was likely with his many comorbidities to become a life threatening condition if left unchecked. It is more likely than not that an incision and drainage of the infection would not have been successful and that the skin changes and mottling noted along with the CT findings likely represented a life threatening condition known as necrotizing soft tissue infection. The only cure for this condition is amputation in this clinical setting as radical debridement of the involved area would not have been successful.
>
> It should be noted that the area of concern on the CT was a new problem above the known Charcot foot that the patient had been treated for previously. The records show that the patient was admitted for a diagnosis of cellulitis/leg abscess/ and osteomyelitis by the vascular surgery service. The reason for his amputation had nothing to do with his well established history of Charcot foot related to his diabetes but rather his overwhelming soft tissue infection around his tibia well above the area of Charcot in his foot.

(Id. at p. 2.) Dr. Jackson, a practicing vascular surgeon also opined:

> Based upon my review of these records I have no doubt that Dr. Brothers and the vascular team arrived at the correct diagnosis of a necrotizing soft tissue infection (necrotizing fasciitis with myonecrosis) - a severe infection of the muscle and deep tissues of the leg. The CT scan findings of extensive gas and infected fluid in the leg muscle, extending well above the ankle and into the middle portion of the leg, clearly and unmistakably support the diagnosis of necrotizing fasciitis with myonecrosis. The accepted standard practice and procedure for this condition requires surgical treatment such as the below knee amputation as was performed by Dr. Brothers. . . .
>
> Given the severity and extent of Lynn's necrotizing fasciitis with myonecrosis, a below the knee amputation was the appropriate treatment and Dr. Brothers' care clearly met the standard of care. The correct diagnosis of necrotizing fasciitis with myonecrosis is independent of any podiatric issues related to either Charcot foot and/or osteomyelitis below the ankle - neither of which had any bearing on the need for below the knee amputation.

(DE 58-4.)

Finally, Defendant's radiology expert Dr. Fritz opined that the gas bubbles in the CT clearly showed a life-threatening, necrotizing soft tissue infection. Dr. Fritz declared that:

> Mr. Lynn presented with an acutely life-threatening, gas-producing, necrotizing infection involving soft tissues overlying the shin above the ankle joint. The gas-producing soft tissue infection and gangrenous muscle tissue necrosis are unequivocally demonstrated on the CT examination dated 1/15/21. The CT images demonstrated tissue necrosis and gas inside the muscle tissues and that the infection had already spread across two muscle compartments cross-sectionally and to the mid-region of the shin.
> . . .
> The necrotizing gangrenous soft tissue infection of the shin musculature was spatially located above the ankle joint line and more remote than that from the midfoot, where previously Charcot foot and possible osteomyelitis were documented. Therefore, the necrotizing gangrenous soft tissue infection was independent of any podiatric-related issues and unrelated to Charcot foot and a previous diagnosis of possible midfoot osteomyelitis.

(DE 58-5.)

Once the movant has made this threshold demonstration, to survive the motion for summary judgment, the nonmoving party *must* "go beyond the pleadings *and by her own affidavits, or by the 'depositions, answers to interrogatories, and admissions on file,' designate 'specific facts* showing that there is a genuine issue for trial.'" Celotex Corp., 477 U.S. at 324 (emphasis added). Under this standard, the mere existence of a scintilla of evidence in favor of the non-movant's position is insufficient to withstand the summary judgment motion. See Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 252 (1986). "Likewise, conclusory allegations or denials, without more, are insufficient to preclude granting the summary judgment motion." Wai Man Tom, 980 F.3d at 1037.

Plaintiffs do not offer any declaration or discovery to oppose the declarations of Defendant's experts. Rather, Plaintiffs' offer Dr. Jacobs' declaration for the conclusion that "there was never any diagnosis of necrotizing fasciitis or other immediately life-threatening infection." However, Dr. Brothers' testimony and Mr. Lynn's medical records indicate that his leg was amputated due to a life-threatening, necrotizing soft tissue infection—not osteomyelitis. Dr. Jacobs does not dispute this testimony stating he "believed Dr. Brothers amputated the leg of Mr.

Lynn to treat the necrotizing fasciitis[.]" (DE 58-1, p. 10.) "It is well recognized that a plaintiff may not avoid summary judgment by submitting an affidavit that conflicts with earlier deposition testimony." Alba v. Merrill Lynch & Co, 198 F. App'x 288, 300 (4th Cir. 2006); see also Barwick v. Celotex Corp., 736 F.2d 946, 960 (4th Cir. 1984) ("A genuine issue of material fact is not created where the only issue of fact is to determine which of the two conflicting versions of the plaintiff's testimony is correct."). Therefore, an inference in a light most favorable to Plaintiffs would be tenuous at best, given it conflicts with Dr. Jacobs' testimony *and* the conclusion rests on speculation and conjecture. See Sylvia Dev. Corp., 48 F.3d at 818.

Furthermore, the Court previously denied Defendant's Motion in Limine to limit or exclude Dr. Jacobs's proffered testimony. Dr. Jacobs opined:

> The medical records indicate clinical signs, symptoms, and radiographic and imaging changes consistent with Charcot's joint disease' and that 'there was never any direct evidence demonstrating osteomyelitis, and the urgent removal of Mr. Lynn's right leg was neither indicated nor necessary and was a departure from the applicable standard of care.

(DE 1-1, ¶¶ 11, 36.) While the Court recognized Dr. Jacobs is qualified to give opinion testimony regarding Charcot's joint disease and osteomyelitis, nevertheless, "an expert witness may not offer an opinion where the subject matter goes beyond the witness's area of expertise." In re Pella Corp. Architect & Designer Series Windows Mktg., Sales Practices & Prods. Liab. Litig., 214 F. Supp. 3d 478, 496 (D.S.C. 2016). Dr. Jacobs concedes he is not qualified to give opinion testimony regarding whether Dr. Brothers deviated from the standard of care for vascular surgeons when he performed the below the knee amputation. Dr. Jacobs testified:

> Q. And as far as the decision of the vascular surgeon to amputate the leg for necrotizing fascitis, that in and of itself is not a deviation in the standard of care of vascular surgery. Are you able to testify on that opinion?
>
> A. Obviously you know as well as I do I cannot testify to vascular surgery standards of care.

(DE 58-1, p. 8.) Further, Dr. Jacobs testified "I can't amputate legs anyway by law . . . ." (DE 58-1, p. 4.) Accordingly, without expert testimony to "establish both the required standard of care and the defendants' failure to conform to that standard," Plaintiffs cannot survive summary judgment. David v. McLeod Reg'l Med. Ctr., 367 S.C. at 247, 626 S.E.2d at 3-4.

The Court finds that based on the experts presented by Defendant and the lack of expert(s) disputing them, Plaintiffs' FTCA medical malpractice claim cannot advance because they do not offer an expert who can establish Mr. Lynn's injuries were proximately caused by any breach in the relevant standard of care.[4]

CONCLUSION

For the foregoing reasons, the Court grants Defendant summary judgment pursuant to Rule 56(f), Judgment Independent of the Motion, as provided herein; therefore, Plaintiffs' case is dismissed.

AND IT IS SO ORDERED.

April 4, 2023
Florence, South Carolina

[4] Plaintiffs' loss of consortium claim must fail for the same reason. See Lee v. Bunch, 647 S.E.2d 197, 202 (S.C. 2007) ("Generally, a plaintiff spouse's claim for loss of consortium fails if the impaired spouse's claim fails, whether the claim is considered separate and independent from the impaired spouse's claim or derivative in nature.").

November 29, 2021

Lee E. Berlinsky
Assistant United States Attorney
United States Department of Justice
District of South Carolina-Charleston Office

Re: Lynn vs. United States of America

Dear Lee Berlinsky,

My name is Rick Delmonte and I practice Podiatric Medicine and Surgery in the Department of Orthopedics at NYU Langone Health. I joined NYU six years ago and was appointed Chief of the division. I specialize in all aspects of foot and ankle surgery with an emphasis on elective and reconstructive procedures. I am certified by The American Board of Foot and Ankle Surgery.

I was hired by Lee Berlinsky and his office to review this case to ascertain any deviation of the standard of care related to the diagnosis of osteomyelitis of a charcot foot and related sequelae leading to the below knee amputation.

I was given the following documents to review and several discs containing x-rays, MRI and CT images:
PDF 0: Pages USA Docs 1-903. Patient Problem List, Problem List,Medications, Vitals, Radiology Reports, Allergies, Lab Results
PDF 1: Pages USA Docs 904-1903. Lab Results, Discharge Summaries,Consult Requests
PDF 2: Pages USA Docs 1904-2903. Consult Requests, Progress Notes(July 2021-Dec 2020)
PDF 3: Pages USA Docs 2904-3903. Progress Notes (Dec 2020-Oct 2019)PDF 4: Pages USA Docs 3904-4903. Progress Notes (Oct 2019-April 2019)

Exhibit 1

PDF 5: Pages USA Docs 4904-5903. Progress Notes (April 2019-Oct2018)
PDF 6: Pages USA Docs 5904-6903. Progress Notes (Oct 2018-July 2017)PDF 7: Pages USA Docs 6904-7903. Progress Notes (July 2017-Nov 2000)
PDF 8: Pages USA Docs 7904-8903. Progress Notes (July 2015-Nov2000)
PDF 9: Pages USA Docs 8904-8946. Progress Notes (Oct 2000-July 2000), Surgical Information (June 13, 2019; January 17, 2019), MedicalPackage Information

After reviewing all the materials provided I was able to formulate an organized opinion that may help determine if there was any deviation by the defendants.
Unfortunately, the diagnosis of Charcot foot within the diabetic patient population is quite challenging for all specialists. The plaintiff was appropriately treated with all recommendations by the defendants including strict non-weight bearing in a CROW device. Several times the plaintiff did not adhere to these important recommendations. More importantly, all imaging done prior to the last CT scan on January 15 were clear of any gas in the tissues. The plaintiff was seen by the DPM in clinic and felt the patient could have had a DVT as the limb was edematous and erythematous. The plantiff sent the defendant for an ultrasound. On the same day the plantiff was told to get an ultrasound for a suspected DVT, the plantiff went to the ED where a CT was performed which found gas in the tissues. The vascular surgeon was consulted and felt this patient was a surgical emergency which unfortunately resulted in a below knee amputation.

In this specific patient with uncontrolled diabetes, elevated BMI, poor nutrition and severe deformity from the charcot foot, it sets up an environment for high risk limb loss. Additionally, the patient showed poor compliance with the recommended non weight-bearing instructions. All visits including the time of diagnosis of gas in the tissues on the CT scan on 1/15 there was no deviation from the standard of care.

It is in my medical opinion and within a reasonable degree of medical certainty that all treatment provided by the plaintiff was appropriate.

Rick Delmonte, D.P.M.,F.A.C.F.A.S.
Chief, Division Podiatric Medicine and Surgery
Department of Orthopedics
NYU Langone Health

Jan Fritz, M.D., P.D., D.A.B.R.
[redacted]Y 10016
PH[redacted]@gmail.com

Monday, November 22, 2021

Lee E. Berlinsky
Assistant United States Attorney
151 Meeting Street, Suite 200
Charleston, South Carolina 29401
(843) 367-5802

Re: Lynn

Dear Mr. Berlinsky:

Upon your request, I reviewed medical records and imaging studies of Keith Edward Lynn, born [redacted] and opine on the imaging findings and interpretation of the right lower extremity from 2017 to the time of below the knee amputation January 2019.

I reviewed select legal documents associated with this case. Documents that were provided to me for evaluation and forming my opinion included:

1. Complaint filed in this lawsuit alleging the deviation of the standard of care owed.
2. Declaration of Plaintiff's Expert Witness Allen Mark Jacobs
3. Pathology report dated 1/17/2019.
4. U.S. Department of Veterans Affairs Medical Records of Mr. Lynn.
5. Imaging studies of Mr. Lynn, including:
    a. Radiographs of the **RIGHT** foot dated 7/23/2017
    b. Radiographs of the **RIGHT** foot dated 6/21/2018
    c. MRI of the **RIGHT** foot dated 7/28/2018
    d. Radiographs of the **RIGHT** and left foot dated 8/13/2018
    e. Radiographs of the **RIGHT** foot dated 10/12/2018
    f. CT of the **RIGHT** lower extremity dated 1/15/2019

I understand additional records and testimony may become available, and I will continue to review the materials as they become available and may have new opinions as discovery continues.

I am in the active practice of Diagnostic Radiology. I am familiar with the national standard of care applicable in this clinical circumstance for reasonable and prudent practitioners when a patient presents for imaging evaluation of acute and chronic conditions of the musculoskeletal system, including bones, joints, ligaments, tendons, nerves, and vessels of the spine, trunk, and extremities.

Personal Background, Training, and Expertise

1. I am a physician and hold board certification in Diagnostic Radiology. I am an Associate Professor of Radiology at New York University Grossman School of Medicine in New York, New York. My curriculum vitae is attached and details my education, publications, and clinical background.

2. I currently work as an attending physician at New York University Langone Health, Bellevue Hospital, and Gouverneur Hospital, all in New York, New York. I also serve as the Musculoskeletal Radiology Departmental Division Chief at New York University Langone Health in New York, New York. I previously served as the Interventional Magnetic Resonance Imaging Service Departmental Director at Johns Hopkins University School of Medicine in Baltimore, Maryland, where I also held the rank of Assistant Professor. As part of my many years of clinical practice, I have assessed and treated adult patients with various acute and chronic musculoskeletal conditions, including infections and neuropathies of the musculoskeletal system and soft tissues, bones, and joints. I have also completed many diagnostic interpretations of radiographs, ultrasonography, computer tomography, and magnetic resonance imaging examinations of patients with osteomyelitis, joint infections, and neuropathic joints. In addition, I have performed many percutaneous image-guided biopsy procedures to obtain tissue specimens for microbiological, laboratory, and pathological examination. Based on my education, clinical experience, training, and knowledge of medical literature, I am intimately familiar with the care and treatment of adult patients with musculoskeletal infections and neuropathic joints.

3. I earned my abitur degree in math and biochemistry from Laura-Schradin Gymnasium in Reutlingen, Germany in 1997 and my Medical Doctorate degree from Eberhard Karls University School of Medicine in Tubingen, Germany in 2005. I completed a residency in diagnostic radiology at Eberhard Karls University in Tubingen, Germany in 2007, as well as internship and residency

in diagnostic radiology at Johns Hopkins University in Baltimore, Maryland in 2012. I then completed a fellowship in musculoskeletal radiology at the Hospital for Special Surgery in New York, New York in 2013. I am a member of multiple radiology societies, boards, professional organizations, and advisory committees, and I have published many medical literature articles and given many presentations in the field of diagnostic radiology. Please see my CV for additional information regarding these positions.

4. I have extensive training and experience in Diagnostic Radiology. This report will summarize my opinions regarding the care and treatment Keith Edward Lynn received at the VA care system.

5. I will specifically discuss the imaging diagnosis of Mr. Lynn's right lower extremity, including radiographs, MRI, and CT examinations preceding the below-the-knee amputation performed in January 2019. I will describe the importance of the imaging findings and their implications for care and treatment decisions.

6. I hold the opinion and will testify that the treatment decision to proceed with the below-the-knee amputation based on the emergent imaging findings and the guarded prognosis was within the accepted standards of practice.

7. The opinions I hold and to which I will testify are all held to a reasonable degree of medical certainty. They are based on my education, training, clinical experience, and familiarity with medical literature associated with the issues, specifically the accepted standards of medical practice that apply to radiologists performing diagnostic imaging interpretation. My opinions were formed by applying well-known and generally accepted principles of science related to medicine. In forming my opinions, I reviewed Mr. Lynn's pertinent U.S. Department of Veterans Affairs medical records from 2017 to 2019.

Review of Records and Time Line

8. Mr. Lynn's medical record from the Charleston South Carolina Veterans Administration Hospital includes insulin-dependent diabetes mellitus, obesity, diabetic neuropathy, history of a motor vehicle collision in 2013 with right and left tibial fractures and recovery complicated by staph aureus infection, asthma, hyperlipidemia, cerebral infarction, cluster headaches, chronic posttraumatic

stress disorder, rotator cuff syndrome, spinal lumbar stenosis, chronic kidney disease stage III, iron deficiency anemia, hypertension, anxiety and depression disorder, gout, sleep apnea, cardiopulmonary disease, episodes of deep venous thrombosis, and diabetic neuropathy with neuropathic arthropathy of the right foot.

9. Imaging studies dating from 7/23/2017 to 10/12/2018, including radiographs, venous Doppler ultrasound examinations, and an MRI of the right foot, demonstrate findings of neuropathic arthropathy ("Charcot foot") with degeneration of the midfoot joints over time, joint effusions, bone marrow edema, osseous fragmentation, synovitis, and periarticular soft tissue swelling. The main differential diagnostic consideration for the imaging appearance is chronic osteomyelitis, which may have co-existed. In addition, there were episodes of deep venous thrombosis.

10. In 2018, Mr. Lynn was evaluated several times for right ankle swelling and decreasing ability to weight-bear and ambulate in the setting of Charcot's foot as the primary working diagnosis, including 8/13/2018 (Dr. Debbie Byron), 10/12/2018 (Dr. Byron), and 11/19/2018 (Dr. Ravenell).

11. In the days preceding 1/15/2019, Mr. Lynn experienced progressive worsening of right lower extremity symptoms, including increasing swelling, redness, discoloration, warmth, and pain. Mr. Lynn also experienced systemic symptoms, including intermittent chills, decreased energy, decreased appetite, and fatigue.

12. On 1/15/2019, Mr. Lynn was reevaluated by Dr. Ravenell, who documented, "There is marked edema at the ankle and midfoot. The foot is warm, and there is mild erythema present."

13. On the same day, 1/15/2019, Mr. Lynn was also evaluated in the emergency department of the Charleston VA Medical Center due to concerns of active infection.

14. Mr. Lynn underwent CT of the right lower extremity on 1/15/2019 interpreted by Dr. McAlhaney, who described cellulitis, osteomyelitis of the distal tibia and fibula, soft tissue gas in the extensor muscle compartment, and fluid collection in the distal calf. These findings were not present on previous imaging examinations.

15. Dr. Brothers was the consulting vascular surgeon. He evaluated Mr. Lynn on 1/15/21 and documented the above stated chief complaint with a history of present illness, and performed a physical examination, which showed "significant edema RLE from the need to the foot with erythema from the ankle to the mid-calf, skin warmth and tenderness to touch, multiple intact erythematous blisters without open wound or drainage". Dr. Brothers further documented Mr. Lynn's inability to bear weight for six weeks and use of a wheelchair. Mr. Lynn was acutely sick at that time with systemic signs of toxicity, including at least one documented episode of vomiting and persistent nausea. Dr. Brothers initiated admission and ordered broadband intravenous antibiotic treatment.

16. On 1/16/2019, the lower extremity remained swollen, red, and warm. An INR of 4 was treated as preparation for below the knee amputation, with the clinical team on standby to perform the amputation faster if clinical decline occurred.

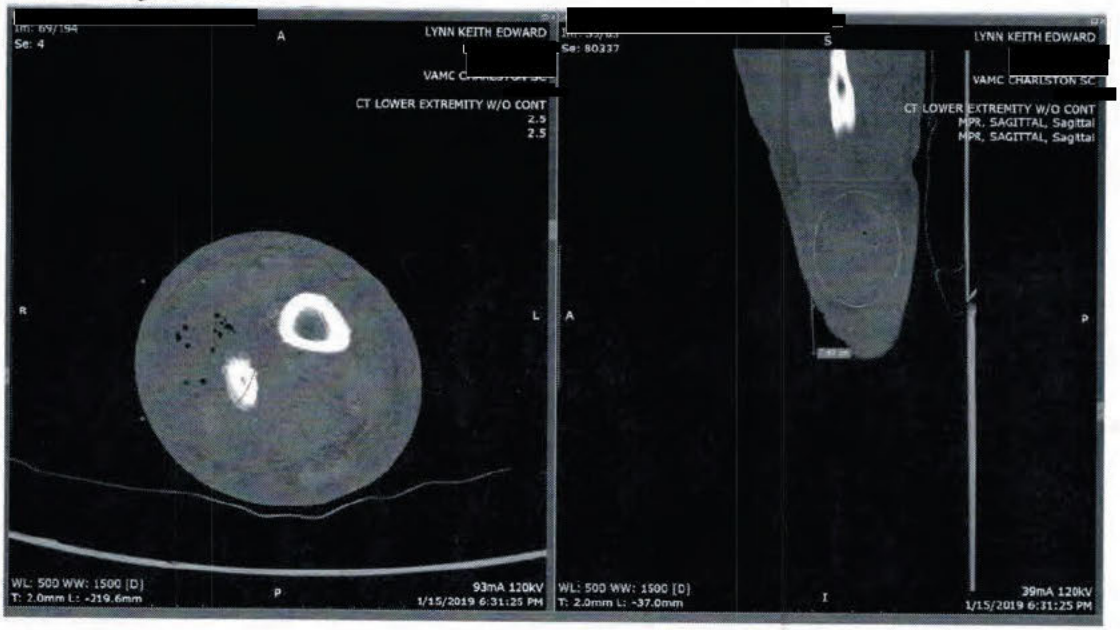
17. On 1/17/2019, the vascular team documented stable conditions with INR at 1.7 and persistent cellulitis, lower extremity swelling and warmth, despite intravenous antibiotic broad-spectrum therapy. The note describes "patient and wife agreeable to below the knee amputation". Surgical consent for below-the-knee amputation was obtained on 1/17/2019 at 904 hours and documented in the medical record. Later in the day, Dr. Brothers performed the below-the-knee amputation.

18. The amputated specimen was sent for surgical pathology examination, which described "purple modeling and brown discoloration" of the skin surface. Dr. Woodham's report further describes that a posterior cut down was performed; however, of note, no anterior cut down was performed in the area of infection, gas gangrene, and tissue necrosis.

Opinions

19. On 1/15/2019, Mr. Lynn presented with an acutely life-threatening, gas-producing, necrotizing infection of the right lower extremity involving soft tissues overlying the shin above the ankle joint. The gas-producing soft tissue infection with osteomyelitis, cellulitis, fasciitis, and muscular tissue necrosis is unequivocally demonstrated on the CT examination dated 1/15/21. The tissue necrosis and gas were located inside muscular tissue and had spread across two

muscle compartments at the CT (extensor and peroneus muscle compartments), spreading from above the ankle up to the mid-region of the shin. The circles below outline the soft tissue gas. The distance measurement of approximately 7.6 cm indicates the distance of the center of the gas-producing infection from the ankle joint line:



20. The constellation of findings is diagnostic of gas gangrene, also known as infectious myonecrosis, which is a surgical emergency. Gas gangrene is part of necrotizing soft tissue infections (NSTIs), including necrotizing forms of infectious fasciitis, myositis, and cellulitis. Colloquially, organisms that cause necrotizing soft tissue infections have also been referred to as "flesh-eating bacteria." In the pelvic region, this infection is also known as "Fournier gangrene". These infections are characterized clinically by fulminant tissue destruction, systemic signs of toxicity, and high mortality. The degree of suspicion must be high since the clinical presentation is variable and prompt intervention is critical. Accurate diagnosis and appropriate treatment must include early surgical intervention and antibiotic therapy.

21. Necrotizing soft tissue infections and gas gangrene typically present with erythema (72 percent, documented by Dr. Brothers), progressively intensifying pain which may be out of proportion to exam findings (72 percent, documented by Dr. Brothers), crepitus (50 percent, documented by Dr. Brothers), and skin bullae 38 percent, documented by Dr. Brothers). Fever is only present in 50% of patients. Because these infections begin deep in the soft tissues, superficial signs of infection may not appear until late in the disease. Ulcers and draining skin

defects are often absent (Stevens DL, Bryant AE. Necrotizing Soft-Tissue Infections. N Engl J Med. 2017 Dec 7;377(23):2253-2265. doi: 10.1056/NEJMra1600673. PMID: 29211672.).

22. The treatment of necrotizing infection consists of early broad-spectrum empiric antibiotic treatment, aggressive surgical resection of necrotic tissue, and hemodynamic support (Anaya DA, Dellinger EP. Necrotizing soft-tissue infection: diagnosis and management. Clin Infect Dis. 2007 Mar 1;44(5):705-10. doi: 10.1086/511638. Epub 2007 Jan 22. PMID: 17278065.).

23. Although the administration of early antibiotic treatment is critical to control systemic toxicity, the mortality rate approaches 100 percent without surgical resection (Anaya DA, Dellinger EP. Necrotizing soft-tissue infection: diagnosis and management. Clin Infect Dis. 2007 Mar 1;44(5):705-10. doi: 10.1086/511638. Epub 2007 Jan 22. PMID: 17278065.)

24. For advanced, severe, and broad-based necrotizing infections involving the extremities, amputation may be needed to control the infection (Anaya DA, Dellinger EP. Necrotizing soft-tissue infection: diagnosis and management. Clin Infect Dis. 2007 Mar 1;44(5):705-10. doi: 10.1086/511638. Epub 2007 Jan 22. PMID: 17278065.; Sudarsky LA, Laschinger JC, Coppa GF, Spencer FC. Improved results from a standardized approach in treating patients with necrotizing fasciitis. Ann Surg. 1987 Nov;206(5):661-5. doi: 10.1097/00000658-198711000-00018. PMID: 3314752; PMCID: PMC1493283.).

25. Primary amputation may be the more expeditious and potentially life-saving intervention for some patients, reducing operative time and blood loss compared with successive debridements. Amputation may also be considered if repeated debridements are unlikely to obtain source control, when functional outcomes are likely to be better with amputation compared with reconstruction, or when no reconstructive options exist (Busse JW, Jacobs CL, Swiontkowski MF, Bosse MJ, Bhandari M; Evidence-Based Orthopaedic Trauma Working Group. Complex limb salvage or early amputation for severe lower-limb injury: a meta-analysis of observational studies. J Orthop Trauma. 2007 Jan;21(1):70-6. doi: 10.1097/BOT.0b013e31802cbc43. PMID: 17211275.: Stineman MG, Kwong PL, Xie D, Kurichi JE, Ripley DC, Brooks DM, Bidelspach DE, Bates BE. Prognostic differences for functional recovery after major lower limb amputation: effects of the timing and type of inpatient rehabilitation services in

the Veterans Health Administration. PM R. 2010 Apr;2(4):232-43. doi: 10.1016/j.pmrj.2010.01.012. PMID: 20430324; PMCID: PMC2917913.; Uehara K, Yasunaga H, Morizaki Y, Horiguchi H, Fushimi K, Tanaka S. Necrotising soft-tissue infections of the upper limb: risk factors for amputation and death. Bone Joint J. 2014 Nov;96-B(11):1530-4. doi: 10.1302/0301-620X.96B11.34888. PMID: 25371469.; Angoules AG, Kontakis G, Drakoulakis E, Vrentzos G, Granick MS, Giannoudis PV. Necrotising fasciitis of upper and lower limb: a systematic review. Injury. 2007 Dec;38 Suppl 5:S19-26. doi: 10.1016/j.injury.2007.10.030. Epub 2007 Nov 28. PMID: 18048033.).

26. The diagnosis of gas gangrene is consistent with Dr. Brothers description of the physical examination "significant edema RLE from the need to the foot with erythema from the ankle to the mid-calf, skin warmth and tenderness to touch, multiple intact erythematous blisters without open wound or drainage". The diagnosis was further corroborated by the CT findings described by Dr. McAlhaney.

27. Mr. Lynn showed systemic symptoms of infection toxicity and acute sickness when seen by Dr. Brothers in the emergency department, including at least one documented episode of vomiting and persistent nausea. Additional constitutional symptoms indicating the systemic toxicity effects of the developing infection were fatigue and decreasing appetite. Based on Mr. Lynn's vital signs, he was not in septic shock in the emergency department. Dr. Brothers prompt initiation of wide spectrum intravenous antibiotic therapy limited the systemic effects and prevented sepsis.

28. Despite broad-spectrum intravenous antibiotic therapy, the lower extremity remained erythematous, painful, swollen, and warm to touch over the next 24 hours. Although the systemic antibiotics stabilized Mr. Lynn's acute sickness, they were ineffective in treating the necrotizing infection locally. This is not unexpected, as the infection had progressed to a large area of active tissue necrosis, which, by definition, is no longer vascularized and therefore may not be reached by the blood supply and intravenous antibiotics.

29. Owing to the ineffectiveness of the antibiotics, imaging documentation of widespread tissue necrosis across to muscular compartments, initial presentation with systemic infection signs, and persistent guarded prognosis with possible death, below the knee amputation was indicated by Dr. Brothers, which falls within the standard of care.

30. On 1/16/2001, Dr. Brothers appropriately considered incision and drainage, which may effectively treat purulent abscesses with non-necrotizing localized pus production. However, Mr. Lynn's right lower leg infection had already passed this stage, as widespread tissue necrosis with bacterial gas production had already occurred, spreading up to the mid-shin region.

31. Mr. Lynn Charcot's arthropathy of the midfoot was unrelated to the indication for below-the-knee amputation. A below-the-knee amputation was required as the gas gangrene was in the anterior aspect of the lower calf (shin region), above the ankle joint line.

32. The pathological report describes a posterior soft tissue incision. As the necrotizing tissue infection was located in the anterior muscle compartments, the pathology description of a posterior soft tissue incision explains why no tissue necrosis was seen.

Conclusions

33. On 1/15/2001, Mr. Lynn presented with advanced gas gangrene necrotizing infection that had spread over two compartments of the anterior calf, which was a surgical emergency. When Dr. Brothers examined Mr. Lynn, Mr. Lynn had signs of systemic toxicity due to the infection and was acutely sick. The infection was located above the ankle and remote from Mr. Lynn's Charcot's arthropathy in the foot below the ankle. Mr. Lynn presented with an acutely life-threatening condition, which has a high mortality rate. Mr. Lynn's prognosis was additionally guarded due to signs of systemic infection toxicity. Dr. Brothers appropriately and promptly initiated intravenous broad-spectrum antibiotic therapy, which stabilized Mr. Lynn. However, despite high dose intravenous antibiotic treatment, the necrotizing gas gangrene infection did not improve over the next 24-48 hours. Consequently, according to the standard of care and with the informed consent of Mr. Lynn and his wife, below the knee amputation was indicated and performed in a timely matter to prevent further complications and death.

My conclusions are based on my knowledge, education, experience, and independent review of the imaging and review of the reports. I also rely on my knowledge of the applicable medical literature.

I hereby certify that this report is a complete and accurate statement of all of my opinions and the basis and reasons for them to which I will testify under oath. I also understand that other experts may author reports in this case, and I will review those and reserve the right to amend or supplement my opinions as additional information is obtained.

New York, NY
11/24/2012

Jan Fritz, M.D., P.D., D.A.B.R., R.M.S.K.

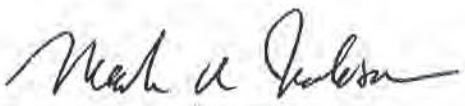
Mr. Keith Lynn, case summary
Prepared by Mark R. Jackson, MD
November 18, 2021

To: Lee E. Berlinsky, Assistant United States Attorney

1. By background I am a board-certified vascular surgeon in the active practice of vascular surgery since completing my vascular surgery fellowship at the Walter Reed Army Medical Center in June of 1993. Upon completion of my vascular surgery fellowship I remained at Walter Reed Army Medical Center as a staff vascular surgeon, while also having appointments at the Uniformed Services University of the Health Sciences in Bethesda, MD as an Assistant Professor Surgery, and also while having an assignment at the Walter Reed Army Institute of Research. I was honorably discharged from the Army in 1997 at the rank of Lieutenant Colonel, and then resumed my vascular surgery career at the University of Texas Southwestern Medical Center in Dallas, where I was promoted to the rank of Associate Professor of Surgery while having an active vascular surgery practice at The Dallas North Texas Veterans Affairs Hospital, Parkland Memorial Hospital, and Zale Lipshy University Hospital. During this time I started an endovascular program within the Division of Vascular Surgery specializing in the then-new technology of abdominal aortic aneurysm stent graft repair. My academic credentials also include publication of over 70 original articles in peer-reviewed journals, book chapters, and published abstracts. I have also presented medical scientific work at national and regional vascular surgery meetings. In 2003 I moved to Greenville, SC were I have continued my career in vascular surgery in the community hospital setting, initially as a hospital-employed vascular surgeon, and now in independent private practice. I have extensive clinical experience treating patient with severe vascular disease of the legs, including performance of procedures to restore blood flow to the legs, and amputation procedures, such as was required for Lynn.
2. In preparation of this report I have reviewed the case files which include close to 9,000 pages. I have also reviewed the source images of the X-rays and CT scans that were performed in the course of Lynn's care. I have also read Dr. Jacobs' written statement regarding the case.
3. The pertinent clinical events are summarized as follows.
4. On Jan 15, 2019, Lynn was seen by his podiatrist, Dr. Ravenell, with redness and swelling of the right foot. Dr. Ravenell's note describes "Marked edema at the ankle and mid foot. The foot is warm and there is mild erythema present." While Dr. Ravenell's assessment was "Charcot neuroarthropathy seems to be in the acute phase" these findings are also consistent with infection of the foot and leg.
5. Later the same day, Jan 15, 2019, Lynn presented to the emergency department for treatment. A vascular surgery consultation was obtained. Dr. Thomas Brothers was the attending vascular surgeon. The consultation documents "significant edema of the right lower extremity from the knee to the foot with erythema from the ankle to mid-calf, skin warm to touch, multiple intact erythematous blisters …" This was followed by the assessment "Right lower extremity osteomyelitis and abscess." Lynn was then admitted to the hospital.
6. A CT scan of the right leg was performed on Jan 15. The radiology report includes the following: "Large gas containing fluid collection 6.8 X 3.4 X 12 cm along the lateral aspect of the fibula. Periostial reaction distal tibia/fibula consistent with osteomyelitis. Large adjacent gas containing fluid collection consistent with abscess. Large complex fluid collection surrounding ankle and hind foot. Not clearly separable from the abscess."
7. Dr. Brothers' note from Jan 16 reads: "Diagnosis: Infected right foot. Procedure: I&D (incision and drainage), debridement, possible amputation right foot."
8. On Jan 17 Lynn underwent a right leg below-the-knee amputation performed by Dr. Brothers, and Dr. Kristen Quinn (presumably the surgical resident).

9. Dr. Brothers' Hospital Discharge Summary (after the amputation) includes the following statements regarding Lynn's medical conditions and hospital presentation, which clearly indicate a medically-compromised patient and the presence of severe infection:
    1. Uncontrolled diabetes
    2. Lynn was non weight-bearing and in a wheelchair for 6 weeks prior to admission due to the Charcot's joint disease.
    3. Lynn presented to the Emergency Department (on Jan 15, 2019) with pain and redness of the right foot and chills for 1 month, and decreased energy, decreased appetite, and fatigue for 4 days.
10. On June 13, 2019 Lynn was again admitted to the hospital and underwent surgical revision of the right leg below-the-knee amputation due to "heterotopic bone growth with pain, right BKA stump."
11. Following is my summary and expert opinion of cared rendered to Lynn. My opinions are within a reasonable degree of medical certainty:
    1. Lynn presented to the Emergency Department with a severe, limb-threatening infection of the right foot and leg.
    2. The clinical findings clearly indicate severe infection and support the medical decision-making resulting in amputation.
    3. The CT scan, in particular, shows extensive soft tissue gas in the right leg. This finding is characteristic of necrotizing fasciitis and myonecrosis, an overwhelming, life- and limb-threatening condition of severe infection, that generally requires a major limb amputation such as was necessary for Lynn. Furthermore, the anatomic extent of infection, as documented on CT by the gas and fluid collection dimensions, provides additional compelling support for the necessity of amputation.
    4. It should be further noted that in cases of necrotizing fasciitis for which amputation is not performed, there is then the risk of systemic, uncontrolled infection (sepsis) that can result in death since all of the dead and infected tissue has not been surgically removed.
    5. Additionally, and with all due respect to Dr. Jacobs, no one is contesting that Lynn also had Charcot's joint disease. The point is that Lynn also, and more significantly, presented with severe, life- and limb-threatening infection.
    6. In summary, based upon my almost 30 years of clinical experience as a fellowship-trained, board certified vascular surgeon with extensive experience treating lower extremity problems in diabetic patients, I find that Dr. Brothers' care in the Lynn case was necessary and appropriate, and clearly meets the recognized standard of care.

Respectfully submitted,



Mark R. Jackson, M.D.

Declaration of John Womack, MD
In the Matter of Lynn vs. United States of America

Nov 23,2021

I am a board certified orthopaedic surgeon with fellowship training in foot and ankle surgery. I have practiced almost exclusively foot and ankle surgery for the past 15 years in Greenville, South Carolina. I take care of patients with diabetic foot problems including Charcot arthropathy on a daily basis including diagnosis as well as both conservative and surgical management of these patients. Mr. Lynn would be a typical patient that I may encounter in my practice on a daily basis. I have attached my CV to this declaration.

I have been hired as an expert witness in the above litigation by the US Department of Justice in Charleston, South Carolina to review the case for a deviation in the standard of care related to the diagnosis and care of this plaintiff and his subsequent right below knee amputation performed at the VA Medical Center in Charleston, South Carolina on 1/17/2019.

I have reviewed extensively the plaintiff's medical records from the VA Medical Center in Charleston from July of 2015 until December of 2020 including all of the outpatient and inpatient notes as well as laboratory tests available to me. I have also reviewed the patient's pertinent imaging studies performed at this institution that relates to the care of the patient's right lower extremity.

It is my medical opinion that Dr. Brothers and the vascular surgery team did not deviate from the standard of care when offering and performing a below knee amputation of this patient's right lower extremity. A review of the patient's care as an outpatient by the Department of Podiatry at the VA shows that he was diagnosed with a right Charcot foot as early as July 28,2018. He was subsequently placed into a CROW AFO by Dr. Byron at Podiatry on August 13, 2018 and was also prescribed an external bone stimulator at that time. The patient had been counseled as to the risk of amputation with the severity of his right foot deformity and reported to his mental health counselor on 11/27/18 that his doctors told him that only 10% of patients with his right foot problem are able to keep their leg. Complicating his lower extremity management was also a history of staph infections from tibia fractures in 2013 that required hardware removal and antibiotics to treat the infections.

The patient presented back to Dr. Ravenell at Podiatry on 1/15/19 complaining of increased pain and swelling in his right leg with 8/10 pain and great difficulty wearing his CROW AFO as a result. Dr. Ravenell also noted that the patient had a fixed deformity of his foot with subluxation of his talus. In addition Dr. Ravenell recommended a doppler ultrasound to evaluate for a deep vein thrombosis and continued non weight bearing on the right leg.

The patient and his wife then presented to the ER that same day, according to the intake nurse's note, seeking a second opinion about his right foot due to the increased swelling and pain in his right leg. Vascular surgery was consulted while the patient was in the ER for management of his right leg. The vascular surgery consultation dated 1/15/19 indicates that the patient had edema of his right lower extremity from the ankle to mid calf with erythematous blisters. I reviewed both the CT report and images from the CT of the right LE performed that

day while the patient was in the ER which demonstrated a 7x12x4 cm abscess of the leg above the ankle level which contained both fluid and gas. It should be noted that the area of concern on the CT was a new problem above the known Charcot foot that the patient had been treated for previously. The records show that the patient was admitted for a diagnosis of cellulitis/leg abscess/ and osteomyelitis by the vascular surgery services. Emergent surgery to remove the leg was not performed as the patient's INR was 4.2 and given his stable vital signs and lack of evidence of sepsis the vascular surgery team elected to better medically stabilize the patient before surgery. It should also be noted that his blood sugar at presentation to the ER was over 400 and that his most recent Hemoglobin A1C was 11.7%.

The patient was then taken to the operating room and underwent a right below knee amputation on 1/17/2019. Of note the patient and his wife therefore had 48 hours to consider the amputation before electing to proceed. The pathology report from the leg specimen shows "purple mottling and skin discoloration." It should be noted that the area of the abscess was not dissected by the pathologists nor were bone biopsies performed which could have confirmed the presence of osteomyelitis. The patient was subsequently discharged in stable condition on 1/23/19.

It is my medical opinion that the decision to perform a below knee amputation does not represent a deviation from the standard of care. The patient had an overwhelming abscess of his leg above his known Charcot foot deformity that was likely with his many comorbidities to become a life threatening condition if left unchecked. It is unlikely that an incision and drainage of the infection would not have been successful and that the skin changes and mottling noted along with the CT findings likely represented a life threatening condition known as necrotizing fasciitis. The only cure for this condition is really amputation in this clinical setting as radical debridement of the involved area would not have been successful.

I submit my above opinions within a reasonable degree of medical certainty.

My opinions may change if additional information is presented for review that may warrant changes.

Respectfully,

John Womack, MD

Curriculum Vitae
John W. Womack, III

[redacted]

Education:

Undergraduate – B.A. History *cum laude* Duke University 1998

Medical school -- M.D. Medical University of South Carolina
Charleston, South Carolina 2002
Elected Alpha Omega Alpha Honor Society 2001

Internship -- University of Tennessee School of Medicine Department
Of Surgery
Memphis, TN 2003

Residency – University of Tennessee – Campbell Clinic Department
Of Orthopaedic Surgery -- 2002- 2007

Fellowship – E.Greer Richardson Foot and Ankle Fellowship –
Campbell Clinic 2007-2008

Board Certification -- ABOS through 2030

Research:

"Evaluation of Shoulder Function in Hemodialysis Patients" Friedman,
Richard J and Womack, John
Medical University of South Carolina 2001

"Long Term Evaluation of Surgical Treatment for Interdigital
Neuroma" Womack, John. And Richardson, E. Greer
Published June 2008 *Foot and Ankle International*
Podium Presentation – American Orthopaedic Foot and Ankle Society
Annual Meeting Summer 2006
Roger A. Mann Award Finalist
Mid-America Orthopaedic Association Annual Meeting 2008

"Clinical Manifestations of Posterior Tibial Tendon Insufficiency"
Clinical Orthopaedic Association Annual Meeting 2007

1. Charcot Arthropathy Versus Osteomyelitis: Evaluation and Management.

Womack J.

Orthop Clin North Am. 2017 Apr;48(2):241-247. doi: 10.1016/j.ocl.2016.12.011. Epub 2017 Feb 1. Review.

PMID: 28336046

2.

Dunking the knot in suture button fixation for distal tibiofibular syndesmosis injury: technique tip.

Watson DJ, Weatherby BA, Womack JW.

Foot Ankle Int. 2012 Aug;33(8):686-8. No abstract available.

3. First metatarsophalangeal arthrodesis.

Womack JW, Ishikawa SN.

Foot Ankle Clin. 2009 Mar;14(1):43-50. doi: 10.1016/j.fcl.2008.11.008. Review.

4. Long-term evaluation of interdigital neuroma treated by surgical excision.

Womack JW, Richardson DR, Murphy GA, Richardson EG, Ishikawa SN.

Foot Ankle Int. 2008 Jun;29(6):574-7. doi: 10.3113/FAI.2008.0574.

5. **Charcot** Arthropathy Versus Osteomyelitis: Evaluation and Management.

Womack J.

Orthop Clin North Am. 2017 Apr;48(2):241-247. doi: 10.1016/j.ocl.2016.12.011. Epub 2017 Feb 1. Review.

PMID: 28336046

Similar articles

From: Berlinsky, Lee (USASC)
To: "Stephen DeAntonio"; "Paul Tinkler"; "William Tinkler"
Subject: Expert witness reports-Lynn
Date: Tuesday, November 30, 2021 12:30:00 PM
Attachments: delmontereport.pdf
Lynn_Fritz report.pdf
markjacksonreport.pdf
womackdeclaration.pdf

Greetings All:

Hope averyone is joyous in the holiday season. Thank you for the courtesies on this production. It is a complicated case. Here are the expert reports in Lynn v USA. As you will see, our case does not really think the focus is on the charcot foot as the cause for the amputation. We believe Mr. Lynn had a much more serious event that was life threatening as it related to his January 15th ED visit. The below knee amputation was related to a gas gangrene event located well above the charcot foot. I would like to discuss this with you after your review, so lets catch up afterwards. I am sending expert C.V.'s by separate email.

Lee

From: William Tinkler
To: Berlinsky, Lee (USASC)
Cc: Stephen DeAntonio; Paul Tinkler; Holmes, Lee (USASC)
Subject: [EXTERNAL] Re: Lynn v USA-PreTrial N-O
Date: Tuesday, November 8, 2022 3:22:28 PM

Thanks, Lee. We just attached the list we sent you several weeks ago.

Sent from my iPhone

> On Nov 8, 2022, at 3:07 PM, Berlinsky, Lee (USASC) <Lee.Berlinsky@usdoj.gov> wrote:
>
> Sorry for any inconvenience. I thought this was sent yesterday. Apologies.
> Lee B.
>
> <pretrialbriefnando.pdf>

From: Paul Tinkler
To: Berlinsky, Lee (USASC)
Cc: Stephen DeAntonio; William Tinkler; Holmes, Lee (USASC)
Subject: Re: [EXTERNAL] Re: Lynn v USA
Date: Wednesday, March 22, 2023 6:03:39 AM

Thanks, Lee.

It's been a while, but I think my Team may have concluded that sending proposed findings of fact and conclusions of law to the fact finder before a trial is a practical impossibility (given, for example, a 9000 page record) and made more problematic by rules regarding ex parte communications . Wouldn't such a document perforce involve the substance of the case?

Does the clerk's communique anywhere direct that we should send such a document ex parte?

These questions I put to you for discussion and, in the event of a hearing, this discussion would come into play.

Paul

On Fri, Mar 17, 2023 at 12:07 PM Berlinsky, Lee (USASC) <Lee.Berlinsky@usdoj.gov> wrote:

> Greetings Paul:
>
> Happy Friday, and hope all is well. Thank you for the clarification because I was not sure what you meant by a "proposed order" which I have not provided anything like that to Chambers. As for the Proposed Findings of Fact/Conclusions of Law that you referenced in your follow-up email, we are not willing to provide that to you under the protection of work product, much like the Pre-Trial Briefs. You and Steve made reference to our submission of the Proposed Findings of Fact/Conclusions of Law in your response to the Rule 56 brief you filed on December 1, 2022 (ECF Filing # 63) as being ex parte and improper. It seems you didn't see or at least didn't appreciate Judge Dawson's filing of his first Notice Regarding Bench Trials which was ECF Docket Entry #42 (Paragraph 5) filed on June 3, 2022, or his second Notice filed on July 25, 2022 ECF Docket Entry #48 (Paragraph 3) **that instructed the parties to file it five days prior to trial** . [Both Notices also instructed the parties how to meet and mark exhibits, which weren't followed accordingly by plaintiff either, so it's quite possible, the Notices weren't seen by your team.] At any rate, we did not act improper and we did not have an ex parte communication with Judge Dawson, quite the contrary.
>
> As always, thank you for the consent to reach out to chambers on a scheduling issue. I will circle back with any response I may receive. If you have any questions or need to discuss the case, we are available. All the best.
>
> Lee

From: Paul Tinkler <paultinkler@tinklerlaw.com>
Sent: Thursday, March 16, 2023 1:39 PM
To: Berlinsky, Lee (USASC) <LBerlinsky@usa.doj.gov>
Cc: Stephen DeAntonio <sdeantonio@deanlawfirm.com>; William Tinkler <williamtinkler@tinklerlaw.com>; Holmes, Lee (USASC) <MHolmes1@usa.doj.gov>
Subject: Re: [EXTERNAL] Re: Lynn v USA

I was thinking you sent proposed findings of fact and conclusions of law to the court, but maybe I dreamed that…

Sent from my iPhone

> On Mar 16, 2023, at 1:34 PM, Berlinsky, Lee (USASC) <Lee.Berlinsky@usdoj.gov> wrote:
>
> What proposed order?
>
> Get Outlook for iOS
>
> ---
>
> **From:** Paul Tinkler <paultinkler@tinklerlaw.com>
> **Sent:** Thursday, March 16, 2023 12:17:41 PM
> **To:** Berlinsky, Lee (USASC) <LBerlinsky@usa.doj.gov>
> **Cc:** Stephen DeAntonio <sdeantonio@deanlawfirm.com>; William Tinkler <williamtinkler@tinklerlaw.com>; Holmes, Lee (USASC) <MHolmes1@usa.doj.gov>
> **Subject:** [EXTERNAL] Re: Lynn v USA
>
> Sure. Can you send us the proposed order you sent to the judge?
>
> Thanks.
>
> Paul
>
> Sent from my iPhone
>
> > On Mar 16, 2023, at 11:58 AM, Berlinsky, Lee (USASC) <Lee.Berlinsky@usdoj.gov> wrote:

With your permission, I may try to call chambers and ask about the scheduling of the pending Rule 56 motion hearing or file a letter asking about it. lease let me know if I have consent.

Lee

From: Paul Tinkler
To: Berlinsky, Lee (USASC)
Cc: Holmes, Lee (USASC); Stephen DeAntonio; William Tinkler
Subject: [EXTERNAL] Lynn v. U.S.
Date: Friday, March 24, 2023 9:31:57 AM

Lee,

I continue to object to the ex parte submission of proposed findings of fact and conclusions of law.
Nowhere does the notice authorize any such document to be submitted ex parte. I have never in my career heard of such an ex parte communication with the court being acceptable.

The claim of "work product" is not applicable. If you have some legal theory or mental impression or notes to prepare for trial, that is work product. But a statement of factual assertions and legal arguments that you supply to the judge, who also is the finder of fact, is not work product. And, if it was, it has been waived by producing it to the judge. I can only surmise that your assertions prompted the judge to raise the questions on which you are now requesting a hearing. The fundamental rules of advocacy require that I be able to review these substantive submissions so that I may be in a position to respond. This is what we call due process of law.

I need a prompt response from you on this. Otherwise I will be required to take this up with the judge forthwith.

Paul

From: **William Tinkler** williamtinkler@tinklerlaw.com
Subject: Re: [EXTERNAL] Lynn v USA
Date: October 19, 2022 at 2:00 PM
To: Lee Berlinsky Lee.Berlinsky@usdoj.gov
Cc: Paul Tinkler paultinkler@tinklerlaw.com, Holmes, Lee (USASC) Martin.Holmes@usdoj.gov, Stephen DeAntonio sdeantonio@deanlawfirm.com, Woods, Saundra (USASC) Saundra.Woods@usdoj.gov, McMillan, Terri (USASC) Terri.McMillan2@usdoj.gov

Lee,

Below is a link to a pdf file with exhibit/witness list and marked exhibits. I wanted to get this to you as you requested, but I note we are still reviewing your exhibits to make sure it is inclusive of the records we intend to refer to at trial. Our assumption is that it is, but if that proves incorrect, we will certainly revise our list accordingly prior to the "meet, mark, and exchange" deadline.

Lynn Exhibit List (with Exhibits).pdf

Let me know if you have any questions or have any issues with the file.

Regards,

William

> On Oct 18, 2022, at 5:17 PM, Berlinsky, Lee (USASC) <Lee.Berlinsky@usdoj.gov> wrote:
>
> Everything is good.
>
> Sent from my iPhone
>
> > On Oct 18, 2022, at 2:48 PM, William Tinkler <williamtinkler@tinklerlaw.com> wrote:
> >
> > Lee,
> >
> > Is everything good on that motion for a status conference? Do you need anything more from us? You have our consent to file.
> >
> > Regards,
> >
> > William
> >
> > > On Oct 14, 2022, at 9:29 AM, William Tinkler <williamtinkler@tinklerlaw.com> wrote:
> > >
> > > Thanks, we'll get it figured out.
> > >
> > > On another note, you can go ahead a file the joint motion for a status conference with our consent.
> > >
> > > > On Oct 14, 2022, at 9:22 AM, Berlinsky, Lee (USASC) <Lee.Berlinsky@usdoj.gov> wrote:
> > > >
> > > > Greetings William:
> > > > I am not sure what files did not open. Are they all of them? That's weird. Wish we would have tried the disc yesterday. I will include Saundra on this email to see what she can suggest.
> > > >
> > > > Until I hear differently, I will assume it's just the Exhibits 2, 3, 4, and 5, which are the imaging studies. We have previously produced those imaging study exhibits on separate discs during Discovery, so maybe those original discs can be accessed by ya'll? I am not sure how to move forward but willing to offer any solution that will work. Can you check the previously produced discs of images that we provided during discovery to see if they worked with your software/hardware.
> > > > Thx.
> > > > Lee
> > > >
> > > > **From:** William Tinkler <williamtinkler@tinklerlaw.com>
> > > > **Sent:** Thursday, October 13, 2022 2:35 PM

Sent: Thursday, October 13, 2022 9:35 PM
To: Berlinsky, Lee (USASC) <LBerlinsky@usa.doj.gov>
Cc: Paul Tinkler <paultinkler@tinklerlaw.com>; Holmes, Lee (USASC) <MHolmes1@usa.doj.gov>; Stephen DeAntonio <sdeantonio@deanlawfirm.com>
Subject: [EXTERNAL] Re: Lynn v USA

Lee,

I got the disc from Steve, and the files on it are in some format I do not have software for. Do you know what I need to do to review them? Is that question for Saundra? For what it's worth, I have a Mac—I know sometimes these programs require a PC.

Thanks,

William

On Oct 13, 2022, at 12:47 PM, Stephen DeAntonio <sdeantonio@deanlawfirm.com> wrote:

Your email comes as a surprise to me. If you were put out, you should have told me to my face. I perceived nothing negative as your email below suggests. We have plenty of time.
I didn't know Saundra drove from Columbia. I regret any inconvenience to her. I neither sensed that.

From: Berlinsky, Lee (USASC) <Lee.Berlinsky@usdoj.gov>
Sent: Thursday, October 13, 2022 12:38 PM
To: Paul Tinkler <paultinkler@tinklerlaw.com>; Stephen DeAntonio <sdeantonio@deanlawfirm.com>; William Tinkler <williamtinkler@tinklerlaw.com>
Cc: Holmes, Lee (USASC) <Martin.Holmes@usdoj.gov>
Subject: RE: Lynn v USA

Greetings All:
Just wanted to circle back after our scheduled court ordered meeting to mark exhibits this morning (see below email setting the date/time). We are disappointed that the meeting did not go as planned with plaintiffs not producing their finalized lists. We gladly would have postponed the meeting if we knew you were not ready to go forward with the Exhibit/Witness list as expected. Our paralegal, Saundra, woke up extra early in her work day and drove from Columbia, SC this morning at 6:00am to help us get the trial exhibits ready and produce our disc of exhibits to you. We are currently in the midst of having several trials going forward, and planning is critical, especially when it involves out of town travel. Now, we are left in a bit of limbo, as we await your finalized document.

Can you please discuss this amongst your team, and send us a

date/time when we can expect this information from plaintiff. **As a courtesy, can we propose the date not be beyond October 19, 2022 at 1:00pm?**
Thank you.
Lee

From: Berlinsky, Lee (USASC)
Sent: Thursday, September 15, 2022 11:48 AM
To: Paul Tinkler <paultinkler@tinklerlaw.com>; Stephen DeAntonio <sdeantonio@deanlawfirm.com>; William Tinkler <williamtinkler@tinklerlaw.com>
Cc: Woods, Saundra (USASC) <SWoods@usa.doj.gov>; McMillan, Terri (USASC) <TMcMillan1@usa.doj.gov>
Subject: Lynn v USA

Greetings All:
Please mark your calendars for meeting to mark exhibits in the Lynn Trial for Thursday, October 13th at 10:30. Our Office location is 151 Meeting Street, Suite 200.
Lee

AO 187 (Rev. 7/87) Exhibit and Witness List

UNITED STATES DISTRICT COURT

DISTRICT OF South Carolina

Keith Lynn and Jennifer Lynn

V.

United States of America

EXHIBIT AND WITNESS LIST

Case Number: 2:20-cv-04277-JD

PRESIDING JUDGE	PLAINTIFF'S ATTORNEY	DEFENDANT'S ATTORNEY
Joseph Dawson, III	P. Tinkler, W. Tinkler, S. DeAntonio	L. Berlinksy, M. Holmes
TRIAL DATE (S)	COURT REPORTER	COURTROOM DEPUTY
11/14/2022-11/18/2022		

PLF. NO.	DEF. NO.	DATE OFFERED	MARKED	ADMITTED	DESCRIPTION OF EXHIBITS* AND WITNESSES
1					Pre-operative Photographs
2					Post-operative Photographs
3					Curriculum Vitae of Allen M. Jacobs
4					Curriculum Vitae of Oliver G. Wood, Jr.
					Keith Lynn
					Jennifer Lynn
					Allen M. Jacobs
					Oliver G. Wood, Jr.
					Debbie Byron (may call if needed)
					Thomas Brothers (may call if needed)
					Rahn Ravenell (may call if needed)

* Include a notation as to the location of any exhibit not held with the case file or not available because of size.

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
CHARLESTON DIVISION

Keith Lynn and Jennifer Lynn,	)	
	)	
Plaintiffs,	)	CA No.: 2:20-cv-4277-JD
v.	)	
	)	
United States of America,	)	
	)	
Defendant.	)	

CIVIL PRE-TRIAL BRIEF: Sections (N) and (O)

(N) The final list of exhibits intended to be used in the trial of the case with any objections noted. This list shall be served on opposing counsel.

The Defendant's exhibit list is as follows:

- Ex. 1 – VA Medical Records Documents 1-8694
- Ex. 2 – C/T Scan 1/15/19
- Ex. 3 – MRI 7/28/18 and 11/21/19
- Ex. 4 – Ultrasound 5/18/18; 6/21/18; 7/09/18; and 1/15/19
- Ex. 5 – X-rays 7/23/17; 6/21/18; 8/13/18; 10/12/18; 1/15/19; and 11/20/19
- Ex. 6 – Atlas of Human Anatomy Plate 501 Leg (A) and (B)
- Ex. 7 – Atlas of Human Anatomy Plate 504 Muscles of Leg
- Ex. 8 – SF-95 Keith Lynn
- Ex. 9 – SF-95 Jennifer Lynn
- Ex. 10 – Dr. Oliver G. Wood, Jr. Information Form
- Ex. 11 – Jennifer Lynn Informed Consent
- Ex. 12 – Keith Lynn Informed Consent

(O) Attached to the pretrial brief should be counsel's request for voir dire questions (*see* Local Civil Rule 47.04) and request for jury instructions. Copies of the requests for voir dire questions and jury instructions shall be served on opposing counsel. If the requests for voir dire and jury instructions are not submitted seven (7) days prior to the selection of the jury, counsel shall be deemed to have waived the right to submit voir dire questions and jury instructions, unless made necessary by events at trial.

Not applicable. This is a non-jury trial.

Respectfully submitted,
ADAIR F. BOROUGHS
UNITED STATES ATTORNEY
By: *s/Lee E. Berlinsky*
Lee E. Berlinsky (ID # 05443)
Martin L. Holmes (ID #13538)
Assistant United States Attorneys
151 Meeting Street, Suite 200
Charleston, SC 29401

November 7, 2022

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
CHARLESTON DIVISION

Keith Lynn and Jennifer Lynn,	)	
	)	
Plaintiffs,	)	CA No.: 2:20-cv-4277-JD
v.	)	
	)	
	)	
United States of America,	)	
	)	
Defendant.	)	
	)	

UNITED STATES OF AMERICA'S PROPOSED *PRE-TRIAL* FINDINGS OF FACT AND CONCLUSIONS OF LAW PURSUANT TO FED. R. CIV. P. 52

The United States of America, by and through the undersigned Assistant United States Attorneys, submits the following Proposed Findings of Fact and Conclusions of Law based upon the anticipated record of the case.

This matter is brought before the Court pursuant to the Federal Tort Claims Act, 28 U.S.C. § 1346 *et. seq*. Plaintiffs' Complaint, filed on December 9, 2020, alleges personal injury stemming from medical negligence that occurred on January 17, 2019, and derivative loss of consortium. The bench trial is scheduled to begin on November 14, 2022.

After hearing the testimony, assessing the credibility of witnesses, and reviewing the exhibits, evidence, and briefs submitted by the parties, the Court should make the following findings of fact and conclusions of law pursuant to Fed. R. Civ. P. 52.

FINDINGS OF FACT

A. Medical Treatment at the Ralph H. Johnson VA Medical Center-Charleston

1. Keith Lynn ("Lynn") testified that he is a fifty-one-year-old resident of Ridgeville, South Carolina, with a complex medical history who was medically separated by honorable

discharge from the United States Navy in June 1997, after serving for approximately seven and one-half years.

2. Lynn testified that he is eligible to receive medical care from the Department of Veterans Affairs ("VA") as a benefit of his naval service, and it is not in dispute that in or around 2000, Lynn established a patient relationship at the Ralph H. Johnson VA Medical Center-Charleston ("VA-CHS").

3. Lynn testified that following his military service retirement, the VA-CHS medical records show long term treatment and care for hypertension, asthma, allergies, obesity, GERD, hyperlipidemia, coronary arteriosclerosis, vascular disease, radicular nerve paralysis, cerebral infarction, diabetes mellitus, factor v leiden mutation, spinal stenosis of the lumbar spine, venous thrombosis, chronic kidney disease, Charcot foot arthropathy, migraines, and mental health related issues.

4. Lynn testified that he received intermittent treatment and care for pain and swelling in his right ankle/foot at the VA-CHS Emergency Department on June 21, 2018, and July 20, 2018.

5. Lynn testified that he received treatment and care for right ankle/foot swelling and pain in the VA-Podiatry Department beginning on August 13, 2018, from Dr. Debbie Byron("Byron"). These symptoms were first identified in the emergency department and confirmed by MRI on July 28, 2018. Lynn testified that Byron diagnosed Lynn with having Charcot foot disease arthropathy.

6. Lynn testified that the Podiatry specialty team at the VA-CHS was treating him for the diagnosis of Charcot joint disease in his right mid-foot area.

7. Lynn testified that Dr. Rahn Ravenell ("Ravenell") is a member of the Podiatry team at the VA-CHS and provided follow-up treatment and care to him on November 19, 2018, and January 15, 2019, for Charcot foot disease.
8. The Court finds that the scope of Podiatry medicine in South Carolina allows patient treatment and care of the foot and ankle.
9. Lynn testified that following the January 15, 2019 clinic visit with Ravenell at the VA-CHS, he went upstairs to the Ultrasound Lab to have a deep vein thrombosis ("DVT") lab test done which was ordered by Ravenell, to determine if a DVT was the cause of the increased leg symptoms. The DVT test was negative.
10. Lynn testified that he went to the VA-Patient Advocate Office immediately after the ultrasound DVT lab test to seek guidance for continued health care concerns. The Patient Advocate referred Lynn downstairs to the VA-CHS Emergency Department for further evaluation.
11. Dr. Rick Delmonte ("Delmonte") testified that he is a retained expert witness in the field of Podiatry Medicine hired by the government and is currently employed at New York University-Langone Health as the Chief of the Division of Podiatric Surgery. Delmonte testified that Dr. Ravenell is a member of the Podiatry team at the VA-CHS and provided follow-up treatment and care on November 19, 2018, and January 15, 2019, to Lynn for Charcot foot disease.
12. Delmonte testified that Ravenell's treatment plan included a non-weight bearing protocol for mobility, confining Lynn to a wheelchair beginning on November 19, 2018.

13. Delmonte testified that Ravenell provided a scheduled follow-up clinic treatment visit on January 15, 2019, where Lynn was seen and evaluated for the Charcot foot disease, noting a patient-reported increase in the swelling and pain in Lynn's leg.
14. Delmonte testified, within a reasonable degree of medical certainty, that Ravenell's podiatric treatment and care of Lynn was appropriate.
15. Delmonte testified that below-knee amputations are outside of the scope of podiatric medicine.
16. Dr. Thomas Brothers ("Brothers") is a vascular surgeon employed by the VA-CHS. Brothers that testified that on January 15, 2019, Lynn was provisionally diagnosed by the Emergency Department physician, Dr. Neil Glover ("Glover"), with a necrotizing soft tissue infection in his leg near the mid-calf/shin area. This is an area separate from where Lynn suffered from Charcot foot disease.
17. Brothers testified that Glover based his provisional diagnosis on radiographic imaging and a C/T Scan that identified large gas bubbles in two separate muscle compartments of the right leg along the anterior and lateral aspect of the fibula between the peroneal muscles and the extensor digitorum.
18. Brothers testified that Glover requested a medical specialty consult by the vascular surgery team for confirmation and treatment of the soft tissue infection. The vascular surgery team, led by Brothers, confirmed the necrotizing soft tissue infection in Lynn's leg and admitted Lynn to the VA-CHS for treatment of the infection.
19. Brothers testified that Lynn's medical record contains the following symptomatic findings consistent with the necrotizing soft tissue infection in addition to the radiographic images taken on January 15, 2019: fatigue, decreased appetite, lack of energy, vomiting, a later

reported episode of nausea, edema from the knee to the foot, erythema from ankle to mid-calf, multiple erythematous blisters, and a glucose lab of 426 mg/dL.

20. Both Lynn and Brothers testified that the VA-CHS health care providers discussed the treatment plan and options with Lynn on several different occasions between January 15, 16, and 17, 2019. The treatment plans discussed included treating the soft tissue infection in Lee's leg with antibiotics and providing surgical interventions, to include an incision and drainage of the infection, a debridement of the infection, or amputation.

21. There is no dispute that Lynn's VA-CHS medical records have inconsistent descriptors of the diagnosis and erroneous descriptions of radiographic images during the January 15, 2019 hospital admission.

22. Brothers testified that during the January 15, 2019 hospital admission, Lynn's health care providers developed a multifaceted treatment plan for his infection and co-morbidities. The descriptors of the infection are described in the medical chart as osteomyelitis, cellulitis, abscess, and a soft tissue infection.

23. Brothers testified that the Informed Consent discussion and the decision to surgically treat Lynn on January 17, 2019, was made between the vascular surgery team and Lynn, including his wife, Jennifer Lynn, who was acting as power of attorney for her husband.

24. Lynn testified that after being informed of the benefits, risks, and alternatives available to treat the soft tissue infection in Lynn's leg, both Plaintiffs provided written consent for the surgical below knee amputation of Lynn's right leg that took place on January 17, 2019.

25. Lynn testified that the vascular team at VA-CHS informed him that they had a treatment plan for incision and drainage of the infection, debridement of the infection, or a below knee amputation of his right leg.

26. The Court finds Plaintiffs' allegation that the amputation was based on insufficient evidence to support a diagnosis of podiatric-related osteomyelitis necessitating amputation is factually misplaced.

27. The Court finds that Lynn had a necrotizing soft tissue infection located deep in his right leg muscle compartments near the shin/mid-calf—a life-threatening infection.

28. The Court finds that the below knee amputation on January 17, 2019, was within the standard of care in vascular surgical medicine to treat the necrotizing soft tissue infection in Lynn's right leg muscle compartments.

29. While Plaintiffs provided adequate testimony to this Court that Charcot joint disease in the foot and osteomyelitis in the foot mimic each other clinically, the Court is not persuaded by Plaintiffs' proffered testimony that this below knee amputation was to treat podiatric Charcot joint disease or osteomyelitis.

30. Brothers testified that the below knee amputation of Lynn's leg for treatment and care of necrotizing soft tissue infections falls under the standard of care offered by the vascular surgery team.

31. Dr. Mark Jackson ("Jackson") testified that he is a retained expert witness for the government in the field of vascular surgery and is currently employed at St. Francis Hospital, Greenville, S.C. Jackson testified that the below knee amputation to treat Lynn's necrotizing soft tissue infection was within the standard of care of vascular surgery.

32. Jackson testified that he treats patients with necrotizing soft tissue infections in their legs and performs below knee amputations.

33. Jackson testified that, within a reasonable degree of medical certainty, the necrotizing soft tissue infection was a large infection in Lynn's leg and the treatment by Brothers was appropriate and necessary.

34. Jackson testified that the necrotizing soft tissue infection in Lynn's leg was separate from the podiatric issues in Lynn's ankle/foot.

35. Dr. John Womack ("Womack") testified that he is a retained expert witness for the government in the field of orthopedic surgery by the government and is currently employed at Bon Secours Hospital, Greenville, S.C. Womack testified that the below knee amputation to treat Lynn's necrotizing soft tissue infection was within the standard of care of treating necrotizing soft tissue infections.

36. Womack testified that, within a reasonable degree of medical certainty, the necrotizing soft tissue infection was a large infection in Lynn's leg and the treatment by Brothers was appropriate and necessary.

37. Womack testified that the necrotizing soft tissue infection in Lynn's leg was separate from the podiatric issues in Lynn's ankle/foot.

38. Womack testified that he treats patients with necrotizing soft tissue infections in patient's legs and performs below knee amputations.

39. Dr. Jan Fritz ("Fritz") testified that he is a retained expert witness for the government in the field of diagnostic radiology with added qualifications in the subspecialty of musculoskeletal radiology and is currently employed at New York University-Langone Health as the Chief of Musculoskeletal Radiology.

40. Fritz testified that gas gangrene is part of necrotizing soft tissue infections, including necrotizing forms of infectious fasciitis, myositis, and cellulitis.

41. Fritz testified that Lynn presented to the VA-CHS with an acutely life-threatening gas producing necrotizing soft tissue infection of the right lower extremity overlying the shin above the ankle.

42. Fritz testified that although systemic antibiotics stabilized Lynn's acute sickness, they were ineffective in treating the necrotizing infection because the infection had progressed to the large area of active tissue necrosis seen in the C/T scan.

43. Fritz testified that, within a reasonable degree of medical certainty, the necrotizing soft tissue infection was a large infection located in two separate leg muscle compartments and the amputation by Brothers was appropriate and necessary.

44. Fritz testified that the necrotizing soft tissue infection in Lynn's leg was separate from the podiatric issues in Lynn's ankle/foot.

45. Fritz testified that he treats patients with necrotizing soft tissue infections and is familiar with the incision and drainage, debridement, and amputation protocols. Although he does not perform those procedures himself, he monitors patients as a radiologist before or after those procedures.

46. Plaintiffs presented the testimony of their only retained medical expert witness, Dr. Allen Jacobs ("Jacobs"), Doctor of Podiatric Medicine, on the issues of standard of care and causation.

47. Jacobs testified that he is not experienced, trained, or skilled to testify on the standards of care in vascular surgical medicine.

48. Jacobs testified that by law, he is prohibited from performing leg amputations, including below knee amputations.

49. Jacobs testified that he cannot express the standards, practices, and procedures of whether other vascular surgeons in the community would have performed a below knee amputation on Lynn.

B. Employment History

50. Lynn testified that he was unemployed at the time of the amputation.

II. CONCLUSIONS OF LAW

A. Liability

1. The United States is the proper defendant in this action pursuant to 28 U.S.C. § 1346(b) and the Federal Tort Claims Act ("FTCA"), 28 U.S.C. § 2671 *et seq.*
2. This Court has jurisdiction over this matter pursuant to 28 U.S.C. §§ 1331 and 1346.
3. The FTCA imposes tort liability on the United States only "in the same manner and to the same extent as a private individual under like circumstances," 28 U.S.C. § 2674, and only to the extent that "a private person[] would be liable to the claimant in accordance with the law of the place where the act or omission occurred." *Id.* at § 1346(b)(1).
4. Under the FTCA, procedural matters are governed by federal law; however, the FTCA directs courts to examine substantive legal issues pursuant to the laws of the place where the act or omission occurred. *Miller v. United States*, 932 F.2d 301, 303 (4th Cir. 1991) ("A plaintiff has an FTCA cause of action against the government only if she would also have a cause of action under state law against a private person in like circumstances."). State law determines whether there is an underlying cause of action. *Dunbar Corp. v. Lindsey*, 905 F.2d 754, 757 (4th Cir. 1990) ("United States liability under the FTCA depends upon state law."). In this case, Plaintiffs allege that the government acted negligently when it performed a below knee amputation at the VA-CHS on January 17,

2019, without first confirming a diagnosis of osteomyelitis. Therefore, South Carolina law governs this action because South Carolina is the site of the alleged tort. 28 U.S.C. § 1346(b)(1).

B. Negligence in South Carolina

5. To prove negligence in South Carolina, a plaintiff must show "(1) a duty of care owed by defendant to plaintiff; (2) breach of that duty by a negligent act or omission; and (3) damage proximately resulting from the breach of duty." *Bloom v. Ravoira*, 529 S.E.2d 710, 712 (S.C. 2000) (citation omitted).

6. Additionally, in South Carolina, a medical malpractice plaintiff will have to prove by a preponderance of the evidence (1) the recognized and generally accepted standards, practices, and procedures in the community that would be exercised by competent physicians in the same specialty under similar circumstances; (2) that the physicians or medical personnel in question negligently deviated from the generally accepted standards, practices, and procedures; (3) that such negligent deviation was the proximate cause of plaintiff's injury; and (4) that the injury can be measured. *Dumont v. United States*, 80 F. Supp. 2d 576, 581 (D.S.C. 2000); *Yonce v. Chaudhary*, No. 1:15-CV-02547-JMC, 2018 WL 1697385 (D.S.C. Apr. 6, 2018) (citing *David v. McLeod Reg'l Med. Ctr.*, 367 S.C. 242, 247-48 (2006)).

7. Under South Carolina law, "[a] physician or surgeon is not an insurer of health, and he is not required to guarantee results [;] [the physician] undertakes only to meet the standard of skill possessed generally by others practicing in his field under similar circumstances." *Dumont*, 80 F. Supp. 2d at 581.

8. Under South Carolina law, expert testimony is required to establish proximate cause in a medical malpractice action if determining the presence of the required causal link is outside the common knowledge or experience of laypersons. *Bramlette v. Charter-Medical-Columbia*, 302 S.C. 68, 72-73 (1990). Plaintiffs must provide expert testimony to establish both the required standard of care and Defendant's failure to conform to that standard. *Pederson v. Gould*, 341 S.E.2d 633, 634 (S.C. 1986); *Cox v. Lund*, 334 S.E.2d 116, 118 (S.C. 1985).

C. Expert Testimony

9. Under Federal Rules of Evidence 104(a) and 702, "the trial judge must ensure that any and all scientific testimony or evidence admitted is not only relevant, but reliable." *Daubert v. Merrell Dow Pharm., Inc.*, 509 U.S. 579, 589 (1993). The Court acts as a gatekeeper "to verify that expert testimony is based on sufficient facts or data." *E.E.O.C. v. Freeman*, 778 F. 3d 463, 472 (4th Cir. 2015) (Agee, J., concurring) (quotations omitted). The trial court must ensure that (1) "the testimony is the product of reliable principles and methods," (2) "the expert has reliably applied the principles and methods to the facts of the case," and (3) the "testimony is based on sufficient facts or data." Fed. R. Evid. 702(b), (c), (d). This entails a preliminary assessment of whether the reasoning or methodology underlying the testimony is scientifically valid," *Daubert*, 509 U.S. at 592-93, and whether the expert has "faithfully appl[ied] the methodology to facts." *Roche v. Lincoln Prop. Co.,* 175 F. App'x 597, 602 (4th Cir. 2006).

10. Because expert witnesses have the potential to be both powerful and misleading, it is crucial that the district court conduct a careful analysis into the reliability of the expert's proposed opinions. *United States v. Fultz*, 591 F. App'x 226, 227 (4th Cir. 2015) (The

Court excluded unreliable testimony that would have been likely to mislead rather than enlighten the fact finder.). "This reliability standard does not require proof 'that the opinion is objectively correct, but only that the witness has sufficient expertise.'" *Donnelly v. Linden Cap. Partners III, L.P.*, No. 2:20-CV-3719-RMG, 2022 WL 2314611, at *2 (D.S.C. June 28, 2022) (quoting *TBL Collectibles, Inc. v. Owners Ins. Co.*, 385 F. Supp. 3d 1170, 1179 (D. Colo. 2018)).

11. The proponent of the expert testimony must establish its admissibility by a preponderance of proof. *Cooper v. Smith & Nephew, Inc*., 259 F.3d 194, 199 (4th Cir. 2001).

12. Under *Daubert*, the court must address two questions: first, whether the expert's testimony is based on "scientific knowledge;" and second, whether the testimony "will assist the trier of fact to understand or determine a fact in issue." *Daubert*, 509 U.S. at 592. The first question is answered by assessing "whether the reasoning or methodology underlying the testimony is scientifically valid." Several factors should be considered when determining the reliability of a particular scientific theory or technique: whether it (1) can be and has been tested; (2) has been subjected to peer review and publication; (3) has a known or potential rate of error; (4) has the existence and maintenance of standards controlling the technique's operation; and (5) has attained general acceptance in the pertinent scientific community. *Id*. at 591-596. In considering these factors, the focus "must be solely on principles and methodology, not on the conclusions that they generate." *Daubert*, 509 U.S. at 593-595. What factors are relevant to the analysis "depends upon the particular circumstances of the particular case at issue." *Kumho Tire Co. v. Carmichael*, 526 U.S. 137, 150 (1999).

13. Courts have looked at the qualifications of the witness in determining whether the proffered opinions are sufficiently reliable to be admissible. *Wehling v. Sandoz Pharmaceutical Corp*., 162 F.3d 1158 (4th Cir. 1998) (Plaintiff wanted to use a pharmacist/toxicologist to testify as an expert but the court said he did not have training, education, or experience in the field of pharmacology or as a medical doctor and was, under *Daubert*, insufficiently qualified to testify on the issues in dispute.); *In Re Paoli R.R. Yard PCB Litig*., 35 F. 3d 717, 749 (3d Cir. 1994).

14. Plaintiffs proffered the expert testimony of a podiatrist to testify on the standards of care of a vascular surgeon. Jacobs testified that he is not trained, experienced, or skilled to testify on the standards of care in vascular surgical medicine. Jacobs testified that he is prohibited by law from performing below knee amputations to treat necrotizing soft tissue infections in his patients' legs.

15. The Court finds that, under *Daubert*, Jacobs is insufficiently qualified to testify on the issues in dispute and that Jacobs does not have the experience, knowledge, or skill to form opinions regarding the standard of care of a vascular surgeon.

D. Damages

16. Because Plaintiffs have failed to establish liability, they are not entitled to damages.

CONCLUSION

Based on the foregoing, the court FINDS AND CONCLUDES that the United States is not liable to Plaintiffs. The medical providers at VA-CHS met the standards of care required when presented with the conditions Lynn described and demonstrated and no negligent act or

omission on behalf of the VA-CHS providers proximately caused any injury to Plaintiffs. Plaintiffs shall take nothing from Defendant. Judgment is entered in favor of the United States.

AND IT IS SO ORDERED.

_____
JOSEPH DAWSON, III
UNITED STATES DISTRICT JUDGE

_____, 2022
_____, South Carolina

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
CHARLESTON DIVISION

Keith Lynn and Jennifer Lynn, Plaintiffs, v. United States of America, Defendant.	**CA: 2:20-cv-04277-JD** **ORDER**

Before the Court is Plaintiffs Keith Lynn and Jennifer Lynn's ("Plaintiffs" or "Lynns") Rule 59(e) Motion for Reconsideration (DE 70) regarding the Court's April 4, 2023, Order and Judgment ("Order") (DE 68) granting Defendant United States of America ("Defendant" or "United States") Summary Judgment pursuant to Rule 56(f), Fed. R. Civ. P. For the reasons set forth below, the motion is denied.

"A district court has the discretion to grant a Rule 59(e) motion only in very narrow circumstances." Hill v. Braxton, 277 F.3d 701, 708 (4th Cir. 2002). Specifically, the Court may reconsider its prior order only "(1) to accommodate an intervening change in controlling law; (2) to account for new evidence not available at trial; or (3) to correct a clear error of law or prevent manifest injustice." Collison v. Int'l Chm. Workers Union, 34 F.3d 233, 236 (4th Cir. 1994) (internal quotation marks omitted). First, the Lynns contend this Court "effectively reversed itself" by granting summary judgment on the basis that their sole medical expert could not offer testimony to meet the Lynns' burden on proximate cause after denying the United States' Motion in Limine to limit the expert's testimony in the field of podiatry.[1] (DE 70, p. 1.) The Lynns contend that "if the Court

[1] The Lynns also contend that the Court granted summary judgment to the United States "without notice to the Plaintiffs." (DE 70, p. 1.) However, the Court draws the parties' attention to its request for, and receipt of, full briefing from the Lynns. (DE 55, 59, 63.) On November 23, 2022, the Lynns filed their

had granted the United States' Motion in Limine, Plaintiffs would have had the opportunity to seek leave to name additional experts." (Id.) However, the Lynns presume the Court would have granted their request to name additional experts, but the second extended deadline to disclose experts expired on December 31, 2021, four months prior to the United States' motion on May 2, 2022. (DE 23, 34.) Discovery closed on March 31, 2022, and the Court ruled on the United States' motion on August 15, 2022. (DE 30, 50.) Therefore, there is no valid basis for the Court to alter its determination or alter or amend its Order in this regard.

Second, the Lynns contend that the Court did not address the Lynns' request to receive a copy of the United States' proposed findings of fact and conclusions of law, which the Lynns contend was an improper *ex parte* communication. (DE 70, p. 2.) Although Plaintiffs acknowledge that they missed a hyperlink requiring Plaintiffs to submit certain information to the Court, they maintain the proposed findings of fact and conclusions of law submitted by the United States should have been provided to Plaintiffs.[2] (DE 72.) In support thereof, the Lynns cite to Canon 3(A)(4) of the Code of Conduct for U.S. Judges, which addresses "*unauthorized* ex parte communication . . . ." Code of Conduct for U.S. Judges Canon 3(A)(4) (emphasis added). However, the Court's Order requiring the parties to submit proposed findings of fact and conclusions of law was an *authorized* communication. In addition, Local Rule 7.10 (B)(4), pertaining to proposed orders, provides:

> Copies of proposed orders will be provided to all counsel of record at the same time and in the same manner as provided to the court; provided, however, that *if the court requests proposed findings and conclusions to be submitted before trial, the court may postpone the required exchange until after trial*.

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first brief in opposition. (DE 59.) On December 1, 2022, they filed their second brief in opposition. (DE 63.)

[2] In response to the Lynns' request for a copy of the Defendants' proposed findings of facts and conclusions of law, the Court directed Defendant to provide the same to Plaintiffs and authorized Plaintiffs to provide a supplemental memorandum with respect to any additional or supplemental matters in support of the Motion for Reconsideration (DE 73), which Plaintiffs filed on July 28, 2023 (DE 75).

Local Civ. Rule 7.10 (D.S.C.) (emphasis added). Likewise, Local Rule 26.05, pertaining to pretrial briefs, provides:

> Absent order to the contrary, the information required by Local Civ. Rule 26.05(A)-(M) (D.S.C.) is *for the sole use of the court and will not be furnished to opposing counsel* without consent of counsel. Therefore, these portions of the trial brief ((A)-(M)) are not served absent order to the contrary. Information contained in (N) and (O) shall be served on opposing parties. Proposed findings and conclusions should not be *submitted with the pretrial brief unless requested by the court*.

Local Civ. Rule 26.05 (D.S.C.) (emphasis added). Despite the Lynns' unauthorized ex parte communication claim, they in turn submitted a pretrial brief to chambers without disclosing its contents to opposing counsel *albeit* in compliance with the local rules and the Notice Regarding Bench Trial (DE 48). The pretrial brief included facts and legal authorities to support their claims and defenses. Ironically, the Lynns interpose no culpability to this *ex parte* communication. Nevertheless, the Notice Regarding Bench Trial (DE 48) directed the parties to submit proposed findings of fact and conclusions of law. The notice also specified that the submission should occur "via email to chambers." (Id.) Nothing about the Court's order superseded the local rules' special treatment of pretrial submissions that could disclose a party's strategic trial decisions. Furthermore, the information provided in the proposed findings of fact and conclusions of law provided by Defendant was not unique to that particular submission because it was equally contained in Defendant's filed briefs, including its Rule 56(f) Brief and attachments thereto. (DE 58.) Accordingly, the Lynns fail to demonstrate an error of law or manifest injustice.[3]

[3] Although the Lynns contend that summary judgment is improper for the reasons stated in their opposition brief, the Court summarily rejects this argument because Rule 59(e) may not be used to relitigate old matters. See Exxon Shipping Co. v. Baker, 554 U.S. 471, 485 n.5 (2008) (recognizing that Rule 59(e) "may not be used to relitigate old matters, or to raise arguments or present evidence that could have been raised prior to the entry of judgment" (internal quotation marks omitted)). Equally, to the extent Plaintiffs' motion for reconsideration is a veiled request for leave to name an additional expert witness in an attempt to overcome the deficiency in their case at the *twelfth* hour, the Court declines to do so. (See DE 75, p. 4.)

Therefore, the Court's Order is not a clear error of law nor manifestly unjust, nor has there been a change in controlling law or new evidence to consider since the ruling. Accordingly, there is no basis to reconsider the Court's prior Order. For these reasons, the Court denies Plaintiffs' motion for reconsideration.

IT IS SO ORDERED.

August 24, 2023
Florence, South Carolina

UNITED STATES DISTRICT COURT
DISTRICT OF SOUTH CAROLINA
CHARLESTON DIVISION

Keith Lynn and Jennifer Lynn, Plaintiffs, vs. United States of America, Defendant.	Case No. 2:20-cv-04277-JD **NOTICE OF APPEAL**

Notice is hereby given that Plaintiffs Keith Lynn and Jennifer Lynn appeal to the United States Court of Appeals for the Fourth Circuit from the orders entered in this action on April 4, 2023 (ECF Nos. 68 & 69) and August 24, 2023 (ECF No. 78), which include the final judgment.

Respectfully submitted,

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October 19, 2023

Counsel for Plaintiffs

CERTIFICATE OF SERVICE

I hereby certify that on October 19, 2023, I electronically filed the **NOTICE OF APPEAL** through this Court's CM/ECF system. I understand that notice of this filing will be sent to all parties by operation of the Court's electronic filing system.

/s/ William P. Tinkler
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